Welcome to Blackstone Valley Community Health Care.

ADULT DEMOGRAPHIC INTAKE (18+ Years Old)

FIRST NAME_____**MIDDLE INITIAL**_____ **LAST NAME**_____

DOB_____ **Patient's Telephone**_____ **Patient's EMAIL**_____

Preferred Language_____ **Preferred Name**_____

Preferred pronouns ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them , Their ☐ Ze, Hir ☐Other_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Street Address_____**APT#**_____

City_____**State**_____**Zip**_____

Emergency Contact_____**Relationship**_____**Phone#**_____

Pharmacy_____**Location**_____**Phone#**_____

PATIENT PORTAL: Are you using our patient portal? __Y __N

Notification Preferences: How should we reach you?	
☐ Voice Reminders	☐ Text Message
☐ Email	☐ Patient Portal

WE ARE REQUIRED TO OBTAIN THE FOLLOWING INFORMATION PER FEDERAL GUIDELINES:

Income Verification: *To be considered for a reduced fee, please circle your family size & annual household income.*

Family Size				
1	2	3	4	5
6	7	8	9	10

******Family Size greater than 10 insert size here*** _____

Annual Income						
$5,000	$10,000	$15,000	$20,000	$25, 000	$30,000	$35,000
$40,000	$45,000	$50,000	$55,000	$60,000	$65,000	$70,000
$75,000	$80,000	$85,000	$90,000	$95,000	$100,000 or greater	

***Total Annual Income_____ **Declined to answer** ☐

See reverse

Housing/Work/Veteran Status *Please check all that apply*
Housing ☐Doubling-up (*sharing a room*) ☐Shelter ☐ Street ☐ Transitional ☐ Permanent Supportive Housing ☐ Not Homeless
Are you any of these ☐Not a Farm worker ☐Migrant Farm worker ☐ Seasonal Farm worker ☐Veteran ☐Not Veteran

RACE *Check all that apply*		**ETHNICITY** *Check all that apply*
□ White	□ Asian Indian	□ Mexican
□ Native Hawaiian	□ Chinese	□ Mexican American
□ American Indian or Alaska Native	□ Filipino	□ Chicano
□ Pacific Islander	□ Japanese	□ Puerto Rican
□ Guamanian or Chamorro	□ Korean	□ Cuban
□ Samoan	□ Vietnamese	□ Hispanic, Latino
□ Black/African American (Cape Verde)	□ Other Asian	□ Not Hispanic or Latino
	□ Unreported/Refused to Report	□ Declined to answer

Sex assigned at Birth: ☐Male ☐Female ☐Undifferentiated

Gender Identity: *Please check the gender identity that you most identify with*	
☐ Female	☐ Female to Male (FTM) (Transgender Male/Man)
☐ Male	☐ Male to Female (MTF) (Transgender Female/Woman)
☐ Gender queer, neither exclusively male or female	☐ Choose not to Disclose
☐ Additional gender category/Other _____	

Sexual Orientation: *Please check the sexual orientation that you most identify with:*	
☐ Straight (heterosexual)	☐ Don't know
☐ Bisexual	☐ Other/Something Else
☐ Homosexual (lesbian, gay)	☐ Choose not to disclose

Patient's Signature_____

Employee Witness_____ **Today's Date**_____

Thank you for selecting Blackstone Valley Community Health Care for your health care needs.
We value our community and welcome you to our health center.

FOR BVCHC INTERNAL USE ONLY: Medical Record #_____Staff initials_____