Welcome to Blackstone Valley Community Health Care!

PEDIATRIC DEMOGRAPHIC INTAKE (0-11 Years old)

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

DOB_____ **Parent's Telephone**_____ **Parent's EMAIL**_____

Preferred Language_____**Preferred Name**_____

Street Address_____ **APT#**_____

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

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

Pharmacy_____**Address**_____**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

WHO IS THE LEGAL GUARDIAN: __Mother __Father __Both __DCYF ___Other:_____

If in parental custody, what is the marital status of the parents: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If in DCYF custody, type of custody: ☐ Petition has been filed ☐ Temporary ☐ Permanent

Case Worker Name:_____ Phone No._____

If in other family custody, does this person have permission to make medical decisions? ☐ Yes ☐ No

PARENT/GUARDIAN NAME_____**DOB**_____ **PHONE #**_____

OTHER PARENT/GUARDIAN NAME_____**DOB**_____ **PHONE #**_____

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

Signature of Legal Guardian _____ **Today's Date** _____

Employee Witness _____

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_____