Demographic Sheet

Today's Date: _____

Patient Legal Name: _____ **Date of Birth:** _____
First Middle Last

Other Names: _____ **Social Security Number:** _____

Address: _____
Street City State Zip

Sex at birth: Male/Female/Other: _____ **Gender Identity:** Male/Female/Other:_____

Race: Black/White/Asian/Am. Indian/Other: _____ **Hispanic:** Yes/No

Marital Status: Single/Married/Separated/Divorced/Widowed **Language:** English/ Other:_____

Cell Phone: _____ **Alternate Phone:** _____

Email address: _____ **Preferred contact:** email/mail/phone/text/any

YES or NO I consent to telehealth services when available for future appointments.
Texting Policy attached.

Allergies: _____ **Family Physician:** _____ **Family Dentist:** _____

Insurance/Medicaid: _____ **WIC:** Yes/No/Applied

Number people in household: _____ **Gross household income:** _____Weekly/Monthly

Highest Level of Education: ____ **Current Student:** Full-time/Part-time/No **School:** _____

Employed: Full-time/Part-time/None **Employer Name:** _____

Emergency Contact Name: _____ **Phone #:**_____

How did you hear about Miami County Public Health and the services we provide?
Family/Friend/Advertisement/Social Media/Doctor Referral/ Other: _____

ONLY Reproductive Health and Wellness Patients complete:

_____(Initial) I am aware that acceptance of family planning services is not a prerequisite of eligibility or receipt of any other service offered at Miami County Public Health.

YES or NO Please bill insurance for Reproductive Health services.

If patient is UNDER 18 years old, please complete:

Mother/Guardian: _____Phone #: _____Date of Birth: _____

Father/Guardian: _____Phone #: _____Date of Birth: _____

My signature provides consent for treatment, acknowledgement of notification of Notice of Privacy Practices verification of voluntarily participating and verification that all information is accurate and correct to the best of my knowledge. Notification that some limitations in confidentiality may be needed in cases of suspected abuse or neglect. I am aware that I am responsible for the contracted price determined by insurance or the sliding fee scale.

Name: (print) _____ **Relationship to patient:**_____

Signature: _____ **Date:** _____