

Patient/Client Information Form

Please answer these private questions. Your information is safe. We update this information every year.

Demographic Information

Patient/Client Legal First & Last Name

Name You Want to Be Called (if different)

Date of Birth (MM/DD/YY)

Sex

Gender

Pronoun: She/Her/Her They/Them/Their

He/Him/His _____

Patient/Client Marital Status: Married Partner Divorced Single Widowed Legally Separated

Street Address

City

Zip Code

County: Adams Arapahoe Denver Douglas Elbert Jefferson Other: _____

Parent/Guardian 1 Name (If patient/client is a minor)

Parent/Guardian 2 Name (If patient/client is a minor)

About You – Answer all questions for the patient/client

- Ethnicity: Hispanic/Latino Not Hispanic
- Race (Select all that apply): White Black/African American Native Hawaiian/Pacific Islander
 Asian American Indian/Alaska Native Middle Eastern/North African Other
- What is your preferred language: English Spanish Other: _____
- Type of health coverage: Medicaid/CHP+ Private Insurance Uninsured Other: _____
Clinic patients, if you are uninsured, would you like help getting health coverage? Yes No
Sometimes getting health coverage is confusing, so ask our Health Coverage Guides for help at any time!
- In the last 60 days, have you experienced any of the following events? (Select all that apply)
Clinic patients, if you have health coverage these life changes need to be updated in your PEAK or Connect for Health Account. Ask us if you need help.

| | | |
|---|---|--|
| <input type="checkbox"/> Moved | <input type="checkbox"/> Had a baby | <input type="checkbox"/> Loss of Health Coverage |
| <input type="checkbox"/> Marriage/Divorce | <input type="checkbox"/> Income or Job Change | <input type="checkbox"/> Legal Status Change |

Income Information

Doctors Care is a non-profit that depends on grants to serve you. For some of our grants we need to share income information of our patients/clients. The information is kept anonymous. For our uninsured patients, we use this information to offer services at a low cost sliding fee.


What is the total income in your household? Current Month \$ _____ OR Annual \$ _____

How many people live in your home? _____ How many people, including you, are on your taxes? _____

(CLINIC PATIENTS ONLY) Pharmacy: We e-Prescribe – no paper!

Pharmacy Name: _____

Address/Cross Streets: _____

| Contact Consent | | | | |
|--|---------------------|--|--|--|
| How to Contact You? | | Brief Message OK? | Detailed Message OK? | |
| Home Phone: | | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | |
| Cell Phone: | | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | |
| Patient's phone if 12-17 years old: | | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No | |
| Email: | | | | |
| Emergency Contact: | | | | |
| Name | | Phone | Relationship | |
| <p>Clinic Patients Only I would like to sign up for the patient portal - a platform to send and receive secure messages via email with Doctors Care about my medical care. <input type="radio"/> Yes** <input type="radio"/> No</p> <p>**Note, the Patient Portal is only available to Clinic Patients ages 0-11 years old and 18 years and over due to special privacy restrictions in place for children ages 12-17. Clients who do not get medical care from the clinic not eligible for the Patient Portal.</p> | | | | |
| Who can we talk to? | | | | |
| Your/your minor's Protected Health Information (PHI) is confidential and protected by Doctors Care. If you want us to be able to talk with someone else (ex. spouse, child, parent) about your/your minor's information list them below. | | | | |
| <input type="checkbox"/> No , I do not allow information to be shared with anyone at this time. | | | | |
| <input type="checkbox"/> Yes , I allow information to be shared with the person(s) listed below. This could include any information related to my/my minor's care or services at Doctors Care. If I am a <u>clinic patient</u> , this could include items related to behavioral health, sexual health, substance use disorders, and other sensitive information. | | | | |
| Full Name | Relationship | Phone Number | Brief Message OK? | Detailed Message OK? |
| | | | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| | | | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| Doctors Care can share my/my minor's information to those listed. This is not a consent to treatment. It does not allow someone to take my place with a minor at a visit. I can change or cancel this release at any time. It will end in one year. | | | | |
|  Signature (Client or Parent/Guardian if Minor) | | Date | | |

Appointment Information

How did you make your appointment?

- By Phone
 Walk In
 Email
 Doctors Care Website
 Connect for Health Colorado Website

How did you learn about services at Doctors Care?

- | | |
|---|--|
| <input type="checkbox"/> Direct Mail (postcard or letter) | <input type="checkbox"/> Medicaid/CHP Provider Website |
| <input type="checkbox"/> Connect for Health Colorado | <input type="checkbox"/> Internet Search |
| <input type="checkbox"/> Current Patient/Client | <input type="checkbox"/> Neighbor/Friend |
| <input type="checkbox"/> County Office: _____ | <input type="checkbox"/> Other Organization: _____ |
| <input type="checkbox"/> Doctor Referral: _____ | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Drive by / Sign | <input type="checkbox"/> School: _____ |
| <input type="checkbox"/> Event: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hospital/ER: _____ | |