Account #: _____

Patient/Client Information Form

Please answer these private questions. You 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)

Contact Consent

Please provide your contact information	Brief Message OK?	Detailed Message OK?
Home Phone: ( ) -	◯ Yes ◯ No	◯ Yes ◯ No
Cell Phone: ( ) -	◯ Yes ◯ No	◯ Yes ◯ No
Patient's phone if 12-17 years old: ( ) -	◯ Yes ◯ No	◯ Yes ◯ No
Email:		

Emergency Contact: Name | Phone | Relationship

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. Not available for non-medical clients or patients 12-18 years old. ◯ Yes ◯ No

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.

☐ **No**, I do not allow information to be shared with anyone at this time.

☐ **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 clinic patient, 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?
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ 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.

Sign

Signature (Client or Parent/Guardian if Minor) | Date

OVER

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? _____

About You – Answer all questions for the patient/client

1. Ethnicity: ◯ Hispanic/Latino ◯ Not Hispanic
2. Race (Select all that apply): ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
   ☐ Asian ☐ American Indian/Alaska Native ☐ Middle Eastern/North African ☐ Other
3. What is your preferred language: ◯ English ◯ Spanish ◯ Other: _____
4. 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!
5. 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.

   ☐ Moved ☐ Had a baby ☐ Loss of Health Coverage
   ☐ Marriage/Divorce ☐ Income or Job Change ☐ Legal Status Change

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

Pharmacy Name: _____

Address/Cross Streets: _____

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?

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