1. **PATIENT INFORMATION**:

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI: \_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Preference: □ Male □ Female □Transgender Male to Female

 □ Transgender Female to Male □ Other

**Sexual Orientation (check all that apply)** **Preferred Gender Pronoun**:

□ Straight or Heterosexual □ Lesbian, Gay or Homosexual □ He/Him

□ Something Else/Other □ Bisexual □ She/Her

□ Questioning/Unknown □ Choose Not to Disclose □ Something Else \_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status**: □ Employed Full Time □ Employed Part Time □ Unemployed □ Retired

**Marital Status**: □ Single □ Married □ Divorced □ Legally Separated □ Widowed □ Partner

1. **GUARANTOR (Parent/Guardian) INFORMATION: (MUST COMPLETE IF PATIENT IS UNDER 18 YEARS OLD)**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **ADDITIONAL INFORMATION**

**What language/s do you speak at home**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Veteran Status**: □ Veteran □ Non Veteran

**Your Housing Situation: Do You Live In**: □ Personal Residence/rental □ Street □ Shelter □ Vehicle/Other □ Doubling Up

1. **RACE INFORMATION** **ETHNICITY**

□ Asian □ Black/African American □ White/Caucasian □ Hispanic/Latino

□ American Indian/Native American □ Native Hawaiian □ More than one race □ Not Hispanic/Latino

□ Alaskan Native □ Pacific Islander □ Unreported/Refused □ Not Reported

1. **IN CASE OF EMERGENCY**

Please give us the name of one person we can call if we cannot reach you and have important medical information we need to inform you of immediately

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Pharmacy**

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Patient Insurance**

**Primary Insurance Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primacy Insurance Holder: **(MUST HAVE TO FILE INSURANCE)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: □ Child □ Wife □ Husband □ Parent □ Patient □ Foster Child □ Step Child

 □ Grandchild □ Niece/Nephew □ Ward of Court □ Self

**Secondary Insurance Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Holder: **(MUST HAVE TO FILE INSURANCE)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: □ Child □ Wife □ Husband □ Parent □ Patient □ Foster Child □ Step Child

 □ Grandchild □ Niece/Nephew □ Ward of Court □ Self

1. **INSURANCE PAYMENT AUTHORIZATION & RELEASE**

I hereby authorize my insurance to be billed by Lawton Community Health Center and acknowledge that I am financially responsible for unpaid balances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guarantor Signature Date