WHITE MOUNTAIN COMMUNITY HEALTH CENTER
Whole Person. Whole Family. Whole Valley.

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Name _____

Physical address _____
Street address

_____
City, State, Zip

Or check ☐ Homeless

Mailing address _____
(if different) *Street address/PO Box*

_____
City, State, Zip

Phone number #1 _____ *Circle one: Home Cell Work*

Phone number #2 _____ *Circle one: Home Cell Work*

Email address _____

Date of birth _____

Marital status *Optional*
☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed

Gender *Optional*
☐ Female ☐ Male

Hispanic/Latino? *Optional*
☐ No ☐ Yes

Race *Optional*
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other

Preferred language *Optional*
☐ English ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Japanese ☐ Russian ☐ Spanish ☐ Vietnamese
☐ Other: _____

EMERGENCY CONTACT

Name:_____

Relationship to patient: _____

Phone number: _____

PARENT/GUARDIAN

If patient is 18 or under

Name:_____

Relationship to patient: _____

Date of birth: _____

Phone number: _____

Mailing address (if different from patient):

Street address

City, State, Zip

HOUSEHOLD INCOME

Please fill this out even if you are insured.

We need to report our patients' average income level to retain our funding. We never share individual information on our patients.

Household income _____

Circle one: weekly monthly yearly

Household size _____

Include anyone living with the patient and supported by the household income.

Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Not employed ☐ Student ☐ Military active duty ☐ Retired

PATIENT (OR PARENT/GUARDIAN) SIGNATURE **PLEASE PRINT NAME** **DATE**

Question for new patients: How did you learn about our services?

☐ Friend/family member ☐ Medical provider ☐ Newspaper ad ☐ Newspaper story ☐ Radio ad ☐ Brochure ☐ Phonebook ☐ Saw sign ☐ Other: _____