Patient Demographic Information

Please provide the information below so we can create your patient record and better understand the communities we serve.

Patient Demographics – New Patient			
Last Name:	First Name:		Middle Initial:
Preferred Name:	Social Security #:		Date of Birth:
Street Address:			PO Box:
City:	State:	Zip:	County:
Home Phone:	Cell Phone:		Work Phone:
Email Address:	Preferred Contact Method: ☐ Call ☐ Text ☐ Email		
Emergency Contact:	Relationship:		Phone:
Preferred Pharmacy:			

Birth Sex – Select One			
What sex were you assigned at birth (i.e., what would be listed on your original birth certificate)?			
☐ Female	☐ Male	☐ Unsure	☐ Decline to specify

Marital Status – Select One				
☐ Married	☐ Partner	☐ Single	☐ Widowed	☐ Legally Separated

Preferred Language for Health Care – Select One			
☐ English	☐ Nepali	☐ Spanish	☐ Other, please specify:

Race – Select all that apply			
☐ American Indian/Alaska Native	☐ Asian	☐ Native Hawaiian	☐ Other Pacific Islander
☐ Black/African American	☐ White	☐ More than one race	☐ Unreported / Refused to Report

Ethnicity – Select One	
☐ Mexican / Mexican American / Chicano/a	☐ Cuban
☐ Another Hispanic, Latino/a, or Spanish origin	☐ Puerto Rican
☐ Not Hispanic, Latino/a, or Spanish origin	☐ Prefer not to answer

Veteran Status – Select One			**Learning Preference – Select all that apply**		
☐ Yes	☐ No	☐ Unknown	☐ Oral	☐ Visual	☐ Written

Sexual Orientation - This information helps us provide respectful and appropriate care		
☐ Straight or heterosexual	☐ Lesbian, gay, or homosexual	☐ Bisexual
☐ Something else	☐ Don't know	☐ Choose not to disclose

Gender Identity - This information helps us provide respectful and appropriate care		
☐ Male	☐ Transgender Male/Female-to-Male	☐ Choose Not to Disclose
☐ Female	☐ Transgender Female/Male-to-Female	☐ Other, please specify:

Attestation Statement

☐ I certify that the information I have provided is true, accurate, and complete to the best of my knowledge. I understand this information will be used to create my medical record, communicate with me about my care, bill my insurance, and determine eligibility for services, programs, or discounts. I agree to notify Hopewell Health Centers if my personal, contact, household, or insurance information changes.

Signature		
Patient Printed Name:	Signature:	Date:
Witness Signature:	Date:	Time:

Patient Demographic Information – Annual Update

Please review your name, address, phone number, insurance, and household information listed above. If any information is incorrect or has changed, please notify staff so it can be updated today.

Patient Demographics – Annual Update			
Last Name:	First Name:		Middle Initial:
Preferred Name:	Social Security #:		Date of Birth:
Street Address:			PO Box:
City:	State:	Zip:	
Home Phone:	Cell Phone:		Work Phone:
Email Address:			
	Preferred Contact Method:	Call ☐	Text ☐ Email ☐
Preferred Pharmacy:			

☐ I have reviewed my information and confirmed that it is correct. I understand Hopewell Health Centers relies on this information for billing, communication, and determining eligibility for programs or discounts.

Signature		
Patient Printed Name:	Signature:	Date:
Witness Signature:	Date:	Time:

For Office Staff Use Only – Identity Verification

Photo ID Scanned: ☐ Yes ☐ No ☐ Not Available

Insurance Card Scanned ☐ Yes ☐ No ☐ Not Available

Patient Photo Captured for Health Record: ☐ Yes ☐ No ☐ Declined