Centros de Salud erie Family Health Centers

New Patient Information

Patient Information

Name (Last) _____ (First) _____ (MI) _____

Street Address_____ Apt. #_____ City_____ State ____ Zip Code_____

Date of Birth: _____/_____/_____
Month Day Year

Parent/Legal Guardian Information (If you are the Parent/Legal Guardian for the patient please complete the Parent/Legal Guardian information.)

Name (Last) _____ (First)_____ (MI)_____

Date of Birth _____/_____/_____ Sex: ☐ Female ☐ Male
Month Day Year

Street Address_____ City_____ State:_____ Zip Code _____

Cell Phone # (____) _____ Home Phone # (____) _____Work Phone # (____)_____

E-mail Address _____

Parent/Legal Guardian*: X_____ Date: _____
*By signing the above line, I attest that the information provided is truthful and accurate.

Patient Contact Information

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Cell Phone (____)_____ Home Phone (____)_____

E-Mail Address: _____

Best way to contact you: ☐ Cell Phone # ☐ Home Phone # ☐ MyErieHealth (Online Patient Portal)

Is it okay to leave voicemail messages? ☐ Yes ☐ No

Is it okay to receive mailings? ☐ Yes ☐ No

Is it okay to discuss your care with someone else? ☐ Yes ☐ No Who? _____

Emergency Contact Name: _____ Relationship to Patient:_____

Emergency Phone # _____

If you would like to opt-out of text messages, please inform the front desk.

Patient Demographics

Please select one of the following:

Marital Status: ☐ Single ☐ Married/Partner ☐ Widow/Widower ☐ Divorced ☐ Separated

Gender Identity: ☐ Female ☐ Male ☐ Trans Female (Male-to-Female) ☐ Trans Male (Female-to-Male)
☐ Other ☐ Choose not to Disclose

Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something Else ☐ Do Not Know
☐ Choose not to Disclose

Race: ☐ American Indian/Alaska Native (Including American Indians or Alaska Natives of Latino/Hispanic descent)

☐ Asian

☐ Black or African American (Including Black or African American of Latino/Hispanic descent)

☐ Native Hawaiian

☐ Other Pacific Islander

☐ White (Including Whites of Latino/Hispanic descent)

☐ Prefer not to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other or Undetermined ☐ Prefer not to answer

Country of Origin (optional) _____

How did you hear about Erie Family Health Centers? _____

Benefits/Insurance Information

Preferred Pharmacy Name/Address: _____

Insurance:
☐ All Kids/Medicaid ☐Medicare ☐Commercial Insurance ☐Erie Sliding Fee Scale Discount Program ☐Other

Insurance Plan:_____ Policy Holder: _____ Policy Number: _____

If you are divorced/separated, is your former spouse/partner financially responsible for medical care? ☐ Yes ☐ No

Family Size: Total number of people living in your house:_____ (dependent children, spouse/partner, other dependents claimed on taxes)

Average Family Annual Income: $_____

All patients, including those with insurance, may be eligible for Erie's Sliding Fee Scale Discount program.
If you selected Erie Discount you must complete the **Sliding Fee Scale Discount Application.**