MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

PATIENT INFORMATION (REV 6/19)

Last Name: _____ **Middle Name:** _____**First Name:**_____

Social Security Number: _____/_____/_____ **Date of Birth:** _____/_____/_____ **Age:** _____

Mailing/Street Address/PO Box: _____

City: _____ **Zip:** _____-_____

Home Phone: _____ **Cell Phone** _____

Email Address: _____**Marital Status:**_____

Preferred Pharmacy: _____ **Preferred Lab:** _____

Primary care provider:_____ **Do you have an Advance Directive?** ☐ Yes ☐ No

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female

Sexual Orientation: ☐ Straight ☐ Lesbian or Gay ☐ Bisexual ☐ Something else
☐ Don't Know ☐ Choose Not to Disclose

In Case of Emergency, Who May We Contact about Your Medical Care?

Last Name: _____ **First Name:** _____

Phone Number: _____ **Relationship to Patient:** _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More than One Race
☐ Refuse to Report Race

Are you Hispanic/Latino? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other _____Interpreter needed ☐ Yes ☐ No

Type of Insurance: ☐ Medicare ☐ Medi-Cal ☐ IEHP Medi-Cal ☐ Private Insurance ☐ No Insurance

Policy Number: _____**Name of Policy Holder:** _____
Relationship to Patient: _____**Date of Birth of Policy Holder** _____

US Veteran? ☐ Yes ☐ No **Do you live in Public Housing ?** ☐ Yes ☐ No

Household Monthly Income:_____**Number of Dependents in Household:**_____ **Refuse to disclose__**

Are you Homeless? ☐ Yes ☐ No

If yes, do you live: ☐ In a Homeless Shelter ☐ In Transitional Housing ☐ Doubled Up with Family/Friends ☐ On the Street ☐ Other Space Not Designed for Sleeping ☐ Unknown

Are you a Migrant Worker? ☐ Yes ☐ No **Are you a Seasonal Worker?** ☐ Yes ☐ No