Welcome to KC CARE Health Center

Please complete all of the information below.

PATIENT INFORMATION

LEGAL FIRST NAME	M.I.	LAST NAME
DATE OF BIRTH	SOCIAL SECURITY #	CHOSEN NAME

PATIENT ADDRESS

STREET		APT #	
CITY	STATE	ZIP	COUNTY

PATIENT MAILING ADDRESS - *If different*

STREET OR P.O. BOX			
CITY	STATE	ZIP	COUNTY

PATIENT COMMUNICATION

HOME PHONE ( )	CELL PHONE ( )	EMAIL ADDRESS

Would you like to sign-up for the patient portal to securely access your health information? ☐ Yes ☐ No

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Text Message ☐ Email

EMPLOYMENT STATUS

☐ Full-time ☐ Self-employed ☐ Part-time ☐ Retired ☐ Unemployed ☐ Active military

EMPLOYER:	JOB TITLE:

ADDITIONAL PATIENT INFORMATION

As a Federally Qualified Health Center, KC CARE is required to collect the following information for statistical purposes only. This is reported in aggregate. Individual patient information is NOT reported. The collection of this information is also required by our grant funders. Thank you for your cooperation.

SEX AT BIRTH
☐ Male ☐ Female

CURRENT GENDER IDENTITY
The gender you identify as, regardless of your biological sex / sex at birth.
☐ Male
☐ Female
☐ Transgender male / Trans man / FTM
☐ Transgender female / Trans woman / MTF
☐ Genderqueer - Not exclusively male or female
☐ Other: _____
☐ Choose not to disclose

SEXUAL ORIENTATION
Do you think of yourself as:
☐ Straight or heterosexual
☐ Bisexual
☐ Lesbian, gay, or homosexual
☐ Something else: _____
☐ I do not know
☐ Choose not to disclose

MARITAL STATUS
☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Life Partner ☐ Separated

PREFERRED LANGUAGE
☐ English
☐ Spanish
☐ Other: _____

ETHNICITY
Are you of Hispanic or Latino origin?
☐ Yes ☐ No

RACE
Please select all that apply.
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ White

HOUSING STATUS
☐ I do not have stable housing:
- ☐ Street
- ☐ Doubling-up / Living with friends
- ☐ Transitional housing
- ☐ Homeless shelter
- ☐ Other: _____

☐ I have stable housing:
- ☐ I own ☐ I rent

VETERAN STATUS
Are you a veteran of the United States Armed Forces?
☐ Yes ☐ No

STUDENT STATUS
☐ Full-time
☐ Part-time
☐ Not a student

AGRICULTURAL STATUS
In the past two years, have you or a member of your family worked in agriculture or farming as your or their primary employment?
☐ Yes – Seasonal work
☐ Yes – Migrant work
☐ No

RESPONSIBLE PARTY INFORMATION - *If different from patient*

FIRST NAME	M.I.	LAST NAME

DATE OF BIRTH	SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY ☐ Spouse ☐ Child ☐ Other: _____

STREET OR P.O. BOX	HOME PHONE	CELL PHONE

CITY	STATE	ZIP	EMAIL ADDRESS

PATIENT ADVANCE DIRECTIVE

Do you have an Advance Directive? *Ex. Living Will, DNR, Power of Attorney*	☐ Yes	☐ No

PATIENT CONTACTS - *Please list one or more emergency contacts*

NAME	RELATIONSHIP

PHONE	☐ Emergency Contact ☐ Primary Contact ☐ Legal Guardian ☐ Resides With

NAME	RELATIONSHIP

PHONE	☐ Emergency Contact ☐ Primary Contact ☐ Legal Guardian ☐ Resides With

MEDICAL INSURANCE

☐ No Medical Insurance

☐ Yes
☐ No

If you do not have medical insurance, would you like a Health Insurance Navigator to contact you about your eligibility for Medicaid, Medicare, or Marketplace health insurance? KC CARE Health Insurance Navigators provide free insurance enrollment assistance to KC CARE patients and their family members.

PRIMARY INSURANCE NAME	POLICY #	GROUP #

POLICY HOLDER NAME	DATE OF BIRTH	SEX ☐ M ☐ F	PATIENT RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ADDITIONAL INSURANCE NAME - *If applicable*	POLICY #	GROUP #

POLICY HOLDER NAME	DATE OF BIRTH	SEX ☐ M ☐ F	PATIENT RELATIONSHIP TO POLICY HOLDER ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

PREFERRED PHARMACY

☐ KC CARE ☐ OTHER (LIST NAME & LOCATION)

PRIMARY CARE PHYSICIAN

FIRST AND LAST NAME: ☐ I DO NOT HAVE A PRIMARY CARE PHYSICIAN

HOW DID YOU HEAR ABOUT US?

☐ ANOTHER PATIENT ☐ INTERNET ☐ FLYER ☐ SOCIAL MEDIA ☐ WORD OF MOUTH ☐ REFERRAL ☐ OTHER:

By signing below, I agree that all information I have provided is true and accurate to the best of my knowledge. I agree to provide updated information if there are any changes to my income, employment, family, and/or insurance.

Please provide guardian signature and relationship if patient is under the age of 18.

Patient / Guardian Signature **Date**

Guardian Relationship

In the event of inclement weather, please check our website, kccare.org, or social media for the most up-to-date information on closings.