Public Health Center – Patient Information Form

Please complete all information requested below, so we can contact you if you need additional tests or treatment, or you miss your appointment

County of Los Angeles Public Health

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Jr/Sr I II III)

Other Name Used: _____ (Last) _____ (First) _____ (MI) _____ (Jr/Sr I II III)

Birth Date: ____ - ____ - ____ (Month Day Year) **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Other

HIE Sharing Entry: ☐ Yes ☐ No

Housing Status: ☐ Not Homeless ☐ Homeless: Staying at a shelter or transitional housing: _____ (Shelter/Transitional Housing Name)

☐ Homeless: Temporary indoor situation (abandoned building, shed, etc.)

☐ Homeless: Use of hotel/motel voucher

☐ Homeless: Living outside (sleeping outdoors, tent, etc.)

☐ Homeless: Staying with family/friend (sleeping on couch, sofa, etc.)

☐ Homeless: Other (specify): _____

Current Address: _____ (Street (if homeless, state cross streets & city)) _____ (Apt. #) _____ (City) _____ (State) _____ (Zipcode)

Home Phone: (____) _____ **Other contact #:** (____) _____ (Cell / Pager (circle))

Mother's Maiden Name: _____ **E-mail:** (optional) _____

Place of work/school: _____ **Work Phone:** (____) _____

Birth Place: ☐ CA ☐ Other State (specify) _____ ☐ Other Country (specify) _____

Social Security #: ____ - ____ - ____ **Medi-Cal #:** _____ **Medicare #:** _____

Insurance Status: ☐ Patient covered by health insurance ☐ Uninsured ☐ Self Pay ☐ No Pay **Policy #:** _____

Primary Insurance: _____ (Insurance Company Name) _____ (Address) _____ (Policyholder Name) _____ (Group No.)

Policyholder/Patient Relationship: ☐ Spouse ☐ Child ☐ Self ☐ Other

Patient Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

Spouse/Partner Name: _____ (Last) _____ (First) _____ (MI) _____ (Jr/Sr I II III)

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Native American/Eskimo/Aleut ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ Filipino ☐ Unknown ☐ Other

Preferred Language:

☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Vietnamese ☐ Korean ☐ Tagalog ☐ Armenian ☐ Cambodian

☐ Russian ☐ Farsi ☐ Other (specify) _____ ☐ **Prefers American Sign Language**

Mother's Full Name: _____ (Last) _____ (First) _____ (Birth Date)

Father's Full Name: _____ (Last) _____ (First) _____ (Birth Date)

Person to Notify in Case of Emergency

Relationship:

☐ Parent
☐ Guardian
☐ Spouse
☐ Domestic Partner
☐ Brother / Sister
☐ Friend
☐ Other

_____ (Last) _____ (First) _____ (MI) _____ (Jr/Sr I II III)

_____ (Street Address) _____ (Unit #) _____ (City) _____ (State) _____ (Zipcode)

Phone: (____) _____ **Cell/Work:** (____) _____

(office use only)

PF#: _____ **Date:** _____ **Updated on:** _____ **CAIR #:** _____