Lamoille Health Partners
Demographic Information

Patient Information *(*If patient is a minor, **Name** and **Number** of Parent or Legal Guardian)*

Last Name *First Name*	*Date of Birth*	*Marital Status*
Physical Address	*Email Address*	
Mailing Address	*Primary Language*	*Social Security Number*
Responsible Party	*Relationship to Patient*	*Primary Phone*

Insurance Information

Primary Insurance		*Insurance Phone*
Primary Insurance Address		*Group Number*
Subscriber Name	*Subscriber Date of Birth*	*Subscriber ID*

Other Information

Employer Name	*Work Phone*
Emergency Contact Name	*Emergency Contact Phone*
Pharmacy Name	*Pharmacy Number*

As a Federally Qualified Health Center we are required to collect the following information

Race: ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ American Indian/Alaskan Native ☐ Multiracial
☐ Other/Refused to Report ☐ Native Hawaiian ☐ Other Pacific Islander

Ethnicity:
☐ Hispanic/Latino ☐ Non-Hispanic ☐ Refuse to Report

Are you a Migrant Worker?
☐ Yes ☐ No

Are you a Seasonal Worker?
☐ Yes ☐ No

Are you a United States Veteran?
☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No
(If yes) ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

The following household information is de-identified and is used to justify our federal funding:

Household size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 or more

Yearly Household Income (please check one): ☐ Less than $22,340 ☐ $22,341–$30,260 ☐ $30,261–$38,180 ☐ $38,181–$46,100
☐ $46,101–$54,020 ☐ $54,021–$61,940 ☐ $61,941 or more If decline, initial here: _____

I voluntarily authorize healthcare agents and employees of Lamoille Health Partners and their designees, as may in their professional judgment be deemed necessary or beneficial, to diagnose and treat my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures. I accept financial responsibility for all charges incurred as a result of such treatment. If insured, I authorize payment of medical benefits to the named provider for services rendered. I also authorize the release of medical information to process any claims.

By signing this form I certify that I understand the authorization to treat outlined above and have received the Patient's Bill of Rights and Responsibilities document and the HIPAA privacy information, and I accept these terms.

Patient or Guardian Signature _____ *Date* _____

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