A. **PATIENT INFORMATION**:

First Name: _____MI: _____ Last Name: _____

Home Address: _____ Apartment Number: _____
City: _____ State: _____ Zip: _____ Phone Number: _____
Date of Birth: _____ Email Address: _____
SSN: _____ Gender Preference: □ Male □ Female □Transgender Male to Female
□ Transgender Female to Male □ Other

**Sexual Orientation (check all that apply)** **Preferred Gender Pronoun**:

□ Straight or Heterosexual □ Lesbian, Gay or Homosexual □ He/Him
□ Something Else/Other □ Bisexual □ She/Her
□ Questioning/Unknown □ Choose Not to Disclose □ Something Else _____

**Employment Status**: □ Employed Full Time □ Employed Part Time □ Unemployed □ Retired
**Marital Status**: □ Single □ Married □ Divorced □ Legally Separated □ Widowed □ Partner

**A. GUARANTOR (Parent/Guardian) INFORMATION: (MUST COMPLETE IF PATIENT IS UNDER 18 YEARS OLD)**

First Name: _____ MI: _____ Last Name: _____

Home Address: _____ Apartment Number: _____

City: _____ State: _____ Zip:_____ Phone Number: _____

Date of Birth: _____ SSN: _____ Gender: _____Relationship to Patient: _____

**B. ADDITIONAL INFORMATION**

**What language/s do you speak at home**? _____ **Veteran Status**: □ Veteran □ Non Veteran

**Your Housing Situation: Do You Live In**: □ Personal Residence/rental □ Street □ Shelter □ Vehicle/Other □ Doubling Up

C. **RACE INFORMATION** **ETHNICITY**

☐ Asian □ Black/African American □ White/Caucasian □ Hispanic/Latino
□ American Indian/Native American □ Native Hawaiian □ More than one race □ Not Hisanic/Latino
□ Alaskan Native □ Pacific Islander □ Unreported/Refused □ Not Reported

**D. IN CASE OF EMERGENCY**

Please give us the name of one person we can call if we can not reach you and have important medical information we need to inform you of immediately

Name: _____ Phone Number: _____
Relationship to You: _____

**E. INSURANCE PAYMENT AUTHORIZATION & RELEASE**

I hereby authorize my insurance to be billed by Lawton Community Health Center and acknowledge that I am financially responsible for unpaid balances.

_____ _____
Patient or Guarantor Signature Date