Please Bring Photo ID, Social Security Card, and Insurance Card

Patient's Name:

Last_____ First_____Middle Initial_____ DOB_____ Sex(M/F/O)

Legal Guardian's Name:_____ - -

(If patient is a minor) Last First Middle Initial

Patient Address:_____

Street Address City State Zip Code

Email Address:_____

Phone Number you wanted to be reached at for results: _____ -- _____ -- _____

Patient's Social Security:_____ - -

Housing Status:

☐ Own ☐ Rent ☐ Public Housing ☐ Section 8 ☐ Other:_____

If OTHER, please identify Homeless Status:

☐ Transitional Housing ☐ Homeless Shelter ☐ Street ☐ Doubled Up ☐ Other:_____

Patient's Gender Identity:

☐ Male ☐ Transgender Male/Female-to-Male ☐ Other

☐ Female ☐ Transgender Female/Male-to-Female ☐ Choose not to disclose

Patient's Sexual Orientation:

☐ Straight or heterosexual ☐ Bisexual ☐ Don't know

☐ Lesbian, gay or homosexual ☐ Something else ☐ Choose not to disclose

Race:

☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Asian ☐ Non-Hispanic White

☐ Black/African American ☐ Other Pacific Islander ☐ Unreported ☐ Hispanic

☐ More Than One Race ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Not Hisp Hispanic ☐ Unreported/Refused to Report ☐ Other Ethnicity:_____

Served in U.S. Armed Forces:

☐Yes ☐ No Patient Classification:

☐No Insurance

☐I have Insurance (please complete below):

Insurance Information

Insurance Company: _____

Subscriber No.:_____Group No.:_____

Policyholder's Name:_____Birthdate:____/____/____

Policyholder's SSN_____

Policyholder's mailing address:_____

City:_____State:_____Zip:_____ Phone:____

Consent: I authorize the health care providers of The Brevard Health Alliance (BHA) to treat, prescribe medications and consent to photograph for purposes of treatment and accurate identification for me, as the providers feel necessary.

OR

I, as the parent or legal guardian/representative of the patient, do hereby give my consent and authorize treatment

Signature:_____ Date: _____

Relationship:_____