NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
PATIENT DEMOGRAPHICS

(All information is strictly confidential)

Last Name:		First Name:	Middle Initial:
Birth Date *(mm/dd/yyyy)*:		Legal Sex: ☐ Male ☐ Female	
Street Address:			City:
State:	ZIP:	County:	Country:
Home Phone:		Work Phone:	Mobile Phone:
E-mail:		MRN *(office use only)*:	

DEMOGRAPHICS

Marital Status: ☐ Married ☐ Domestic Partner ☐ Significant Other ☐ Divorced ☐ Legally Separated
☐ Single ☐ Widowed ☐ Other

Ethnic Group: ☐ Hispanic, Latino/a, or Spanish Origin ☐ Non-Hispanic or Latino/a
☐ Multiple Hispanic, Latino/a, or Spanish Origins ☐ Mexican/Mexican American, or Chicano/a ☐ Cuban
☐ Puerto Rican ☐ Refused to Report

Which of the following groups do you belong to? ☐ White ☐ Black/African American ☐ American Indian
☐ Alaska Native ☐ Native Hawaiian ☐ Samoan ☐ Filipino ☐ Guamanian or Chamorro ☐ Other Pacific Islander
☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Korean ☐ Asian Indian ☐ Other Asian ☐ Refused to Report

Homeless Status: ☐ Not Homeless ☐ At Risk for Homelessness ☐ Child at Risk for Homelessness
☐ Currently not Homeless, was in the last 12 months ☐ Homeless Unknown Shelter ☐ Living in Shelter
☐ Living with Others ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel ☐ Street, Camp, Bridge
☐ Transitional Housing ☐ Veteran at Risk for Homelessness ☐ Unknown/Unreported

Migrant (Agricultural) Worker Status: Are you a farmworker? ☐ Yes ☐ No
If yes, please check appropriate box: ☐ Migrant Worker (moves around) ☐ Seasonal Worker (stays in place)

Emergency Contacts

Name:	Relationship:	Primary Phone:
Name:	Relationship:	Primary Phone:
Name:	Relationship:	Primary Phone:

Are you currently employed? ☐ Yes ☐ No	Are you currently an employee of NVHC? ☐ Yes ☐ No

Needs Interpreter: ☐ Yes ☐ No	Preferred Language:

Veteran Status: Are you a veteran? ☐ Yes ☐ No
If yes, please check appropriate box:
☐ Active Duty ☐ Inactive Duty ☐ No previous experience ☐ Reservist ☐ Uncollected

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Responsible Party			
Last Name:	First Name:		Middle Initial:
Birth Date *(mm/dd/yyyy)*:	Legal Sex: ☐ Male ☐ Female		
Street Address:		City:	
State:	ZIP:	County:	Country:
Home Phone:	Work Phone:	Mobile Phone:	
E-mail:			

Number of eligible family members on your federal tax filing (including self):

Annual Income: *(We need this information for statistical purposes)*

☐ $0 (no income) ☐ $1 to $15,059 ☐ $15,060 to $21,596 ☐ $21,597 to $30,119
☐ $30,120 to $37,649 ☐ $37,650 to $45,179 ☐ $45,180 to $60,239 ☐ $60,240 to $74,999
☐ $75,000 to $104,899 ☐ $104,900 or more ☐ Refused to report (Initials _____)

Insurance Information			
Primary Insurance:	Member ID:	Group Number:	Claim Address:
Subscriber Name:	DOB:	Employer:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Secondary Insurance:	Member ID:	Group Number:	Claim Address:
Subscriber Name:	DOB:	Employer:	Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

I hereby voluntarily consent to outpatient care with Nevada Health Centers, Inc., encompassing routine, minor surgical and diagnostic procedures. I furthermore consent to the performance of examination and procedures by the medical staff and their assistants, including physician assistants and advanced practice nurses. I understand that physician assistants and advanced practice nurses are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I agree to the release of medical records and information including those related to medical treatment, surgical procedures, laboratory testing, psychological services and consultations to any person or entity responsible for payment to NVHC.

_____ _____

Signature of Patient, Parent or Legal Guardian Date