NORTHEAST HEALTH DISTRICT
CLIENT INFORMATION

Name:

Last: _____ Suffix: _____ Middle: _____

First: _____ Prefix: _____ Maiden: _____

Social Security Number: _____ **Date of Birth:** _____

Sex: ☐ Male ☐ Female

Transgender: ☐ MF ☐ FM

_____
Mother's Maiden Last Name:
(required for immunizations)

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Education: _____
Number of years

Foster Care: ☐ Yes ☐ No
If yes, date placed: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Race:
☐ White
☐ Black/African American
☐ Asian
☐ Multi-racial
☐ Native American/Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Other
☐ Unknown/Declined to Report

Primary Language:
☐ English ☐ Japanese
☐ Spanish ☐ Korean
☐ Chinese ☐ Vietnamese
☐ French ☐ Other non-English
☐ **Interpreter needed**

Mobile phone: _____ **Personal email:** _____

Home phone: _____ **Work email:** _____

Work phone: _____

Mailing Address: _____

_____ _____ _____ _____
City State Zip Code County

Physical Address: _____

_____ _____ _____ _____
City State Zip Code County

Emergency Contact: _____ _____ _____
Name Phone number Relationship

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Living Situation *(choose one)* :

- ☐ Own House
- ☐ Rental House
- ☐ Apartment
- ☐ HUD/Section 8
- ☐ Transitional Housing
- ☐ With Family
- ☐ With Friends
- ☐ Homeless
- ☐ Adult Foster Care
- ☐ Skilled Nursing Facility
- ☐ Personal Care Home
- ☐ Hospice
- ☐ Emergency/Shelter
- ☐ Other

Describe *(stability, safety, affordability, etc.)* :

Preferred Care Providers

	Name	Phone Number
Primary Care:		
Pharmacy:		
Dental:		
Mental Health:		

Do you have any legal issues that may affect your health care, such as an Advanced Directive of Health Care or a "living will?" ☐ Yes ☐ No

Employment

Employer Name	Phone Number