**Lyon-Martin Health Services**
**Patient Demographic Information**

***LMHS Chart #: _____***

**Date: _____**

Preferred Name: _____

Home Address (including city, state, and zip): _____

Mailing Address (including city, state, and zip): _____

Date of Birth: _____ SSN: _____-_____-_____

Phone Number: _____ Email Address: _____

Can we leave you a confidential message at this phone number? Yes No

If you don't have contact information, what other social service agencies do you frequent?

_____

What type of insurance(s)/coverage(s) do you have? ***We treat everyone regardless of ability to pay.***

- ☐ None
- ☐ Healthy SF
- ☐ CDP
- ☐ Family Pact
- ☐ Medi-Cal
- ☐ San Francisco Health Plan Medi-Cal
- ☐ Medicare
- ☐ Anthem Blue Cross Medi-Cal
- ☐ Other: _____

For billing purposes, if you have insurance, what gender do they have on record for you? ☐ Female ☐ Male

Name listed on your insurance card: _____

*We must collect ALL patients' income information in order to stay in compliance with Federal Regulation, as Lyon-Martin is a Federally Funded Community Health Clinic. (Even if you have insurance).*

My head of household is: _____, & additional # members: _____. My household's **taxable annual** income is: _____ **OR** my household's **taxable monthly** income is: _____

*Due to Federal Regulations, we must ask ALL patients their household size and income, regardless of health insurance status. Household members include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.*

What type of **taxable** income do you have? *We treat everyone regardless of ability to pay.*

- ☐ None
- ☐ Full-time Employment
- ☐ Part-time Employment
- ☐ Unemployment
- ☐ SSI
- ☐ Disability
- ☐ Child/Care Support
- ☐ Alimony
- ☐ Other: _____

**Please Complete Backside**

**Preferred Pharmacy:**

Pharmacy Name: _____

Location:_____ Phone Number:_____

**Emergency Contact: _____**

**Relationship: _____**

**Phone Number: _____**

**My preferred language is:**

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

**Check all that apply:**

**My gender identity is:**

- ☐ Woman
- ☐ Man
- ☐ Trans (MTF)
- ☐ Trans (FTM)
- ☐ Genderqueer
- ☐ Other: _____
- ☐ Decline

**My sex assigned at birth is:**

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Other: _____
- ☐ Decline

**My marital status is:**

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Registered Domestic Partner
- ☐ Widowed
- ☐ Unmarried Partner
- ☐ Legally Separated
- ☐ Other: _____
- ☐ Decline

**My sexual orientation is:**

- ☐ Lesbian
- ☐ Gay
- ☐ Queer
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Asexual
- ☐ Questioning
- ☐ Other: _____
- ☐ Decline

**My pronoun is:**

- ☐ She/her
- ☐ He/his
- ☐ They/Them/Their
- ☐ Zie/Hir
- ☐ Other: _____

**I live (please check all that apply):**

- ☐ In a house or apartment or SRO or hotel
- ☐ In an RV or vehicle
- ☐ On the street
- ☐ In a shelter
- ☐ In a transitional or treatment program
- ☐ My situation is temporary and/or unstable

**I am Hispanic/Latin@/Latinx:** Yes No

**My race is:**

- ☐ Native American and/or Alaskan Native
- ☐ Hispanic/Latin@/Latinx
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Other: _____
- ☐ Decline

**I am a veteran:**

Yes No

**I am a seasonal agricultural worker:**

Yes No

***For Office Use Only:***

*Entered into EPM by: _____ on: _____*