wesley Health Centers
JWCH INSTITUTE

PATIENT INFORMATION FORM

PN# _____ **TODAY'S DATE:** _____ **FORM EXPIRATION DATE:** _____

NAME: _____
Last First MI

PATIENT IS ALSO KNOWN AS: _____

GENDER IDENTITY: ☐Male ☐Female ☐Transgender: Male to Female ☐Transgender: Female to Male ☐ Decline to State ☐Other _____

SEXUAL ORIENTATION: ☐Straight/Heterosexual ☐Lesbian/Gay ☐Bisexual ☐Don't Know ☐ Decline to State ☐Other _____

CONTACT PREFERENCE: ☐Residence ☐Mail ☐Phone ☐Text ☐ Email: _____ ☐Other _____
Do Not Contact By: ☐Phone ☐Mail ☐Text ➡ If all checked, how to contact : _____

(____) _____ (____) _____ (____) _____
Primary Phone Work Phone Cell Phone

RESIDENTIAL ADDRESS: _____
Street City State Zip

MAILING ADDRESS: _____
Street City State Zip

DATE OF BIRTH: _____ **BIRTH PLACE:** _____ **SOC. SEC #:** _____ - _____ - _____
mm/dd/yyyy City/State/ Country

DRIVER LICENSE #: _____ **MOTHER'S MAIDEN NAME:** _____

EMERGENY CONTACT: _____

RELATIONSHIP TO PATIENT: ☐Parent ☐Spouse ☐Relative ☐Guardian

ADDRESS: _____
Street City State Zip

(____) _____ (____) _____ (____) _____
Primary Phone Work Phone Cell Phone

ETHNICITY: ARE YOU HISPANIC?: ☐Yes ☐No ☐Decline to State

RACE: Select Applicable
☐White
☐Black/African American
☐Native American/ Alaskan
☐Pacific Islander
☐Unknown
☐Asian
☐Native Hawaiian
☐Decline to State

MARITAL STATUS:
☐Single
☐Married
☐Divorced
☐Widowed
☐Domestic Partner
☐Separated
☐Unknown
☐Decline to State

EMPLOYMENT:
☐Full-Time
☐Part-Time
☐Retired
☐Student
☐Self-Employed
☐Unemployed
☐Temp
☐Other: _____
☐Unknown
☐Decline to State

PRIMARY LANGUAGE:
☐English ☐Arabic
☐Spanish ☐Sign Language
☐Cantonese ☐Cambodian
☐Hindustani ☐Hmong
☐Japanese ☐Armenian
☐Vietnamese ☐Russian
☐Korean ☐Tagalog
☐Punjabi ☐Laotian
☐Portuguese ☐Other: _____
☐Mandarin

TRANSLATOR NEEDED:
☐Yes ☐No ☐Refused

WHAT IS YOUR NATIVE LANGUAGE?: _____

WHAT IS YOUR PREFERRED LANGUAGE?: _____

SOURCE OF INCOME: ☐EMPLOYMENT ☐SSI/SDI/SSDI ☐GR/TANF **ARE YOU A VETERAN?:** ☐Yes ☐No

ARE YOU DISABLED?: ☐Yes ☐No **IF YES, TYPE OF DISABILITY**: _____

MIGRANT WORKER?: ☐ Yes ☐No **PUBLIC HOUSING?:** ☐No ☐Public Housing ☐ Tenant Based Voucher ☐Other

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PATIENT NAME: _____ (Last First MI)
DOB:
PN#

ARE YOU A U.S. CITIZEN? ☐Yes ☐No

LIVING SITUATION:
☐ House/ Apt. ☐ Transitional ☐Doubling Up (Staying with Friends or Family) ☐Street ☐Unknown ☐ Other _____

☐ Shelter: Name: _____

Have you moved twice within the last 2 years? ☐Yes ☐No

If staying on the streets, what cross streets do you tend to frequent? _____ City/ Zip Code: _____

HOW LONG HAVE YOU BEEN IN CURRENT LIVING SITUATION? _____

HIV STATUS:
ARE YOU AWARE OF YOUR HIV STATUS? ☐Yes ☐No **IS YOUR SPOUSE/PARTNER AWARE OF YOUR HIV STATUS?** ☐Yes ☐ No

IF HIV POSITIVE, HOW DO YOU BELIEVE YOU WERE EXPOSED:
☐Mother with at Risk for HIV Infection ☐Hemophilia or Coagulation Disorder ☐Men who have Sex with Men
☐Heterosexual Contact ☐Sharing Needles ☐Other: _____

CURRENT RISK BEHAVIORS: ☐Needle Sharing ☐Non-Injection Substance Abuse ☐Exchange Sex ☐No current Risk Behavior ☐Unprotected Sex ☐Other: _____

DO YOU SMOKE? ☐Yes ☐No

DO YOU HAVE A HISTORY OF USING DRUGS/ALCOHOL? Yes ☐No

ARE YOU DIABETIC? ☐ Yes ☐No

HAVE YOU TAKEN PAIN MEDICATION FOR LONGER THAN YOUR DOCTOR PRESCRIBED? ☐ Yes ☐No

MONTHLY INCOME: $ _____ **FAMILY SIZE:** _____ **HIGHEST LEVEL OF EDUCATION:** _____

FOR STAFF USE ONLY

Type of Coverage: ☐ Medical ☐ Dental ☐ Other: _____

☐ Self-Pay	
Sliding Fee	Schedule: A B C D E F
Discount:	%

☐ County			
MHLA	*MHLA #:*		
Effective:		*Expires:*	

☐ Federal	
Medicare	*HIC #:*
Part B Effective:	
Plan Name:	
PCP:	

☐ Private	
Covered California: ☐ Yes ☐ No	
Plan Type: ☐ HMO ☐ PPO	
Network: ☐ Yes ☐ No	
Policy #:	
Plan Name:	
PCP:	
Policy Effective:	$
Copay Amount:	$
Deductible Amount:	$

☐ State			
Medi-Cal	*BIC #:*		
	Plan Name (HCP):		
Effective:		*Expires:*	
CHDP	*BIC #:*		
CPSP	*PE#:*		
Effective:		*Expires:*	
Family Pact	*HAP#:*		
Effective:		*Expires:*	
SOC	*Spenddown Amount:*	$	

Dates of Verification: _____ _____ _____ _____ _____
Staff Initials: _____ _____ _____ _____ _____

My signature below certifies that the information provided above is factual and accurate. I understand that any falsification, omission or concealment of material information may result in my discharge from any of the Wesley Health Center Clinics and/or I may be held responsible for payment of some or all of the services I will receive. I also agree to update my information as my situation changes or at least yearly.

Applicant Signature: _____ Date: _____