LEGACY COMMUNITY HEALTH

CLIENT INTAKE

Legacy Community Health No Show Policy Effective 03/01/2022	Any patient who misses an appointment three times without calling 24 hours in advance to reschedule or cancel, will no longer be able to schedule appointments by phone. Patients will only be able to schedule appointments, in person, at the front desk of one of our locations.	**Initials:** _____

PATIENT INFORMATION (PERSON RECEIVING CARE)

TODAY'S DATE	PATIENT FIRST NAME	PATIENT MIDDLE NAME	PATIENT LAST NAME

PREFERRED NAME (IF APPLICABLE)	MOTHER'S MAIDEN NAME	DATE OF BIRTH	*AGE*

FOR STAFF USE: PATIENT PHOTO ID (18 AND ABOVE) / PARENT OR LEGAL GUARDIAN PHOTO ID (IF PATIENT UNDER 18)

☐ Driver's License ☐ Passport ☐ State ID ☐ Other: _____

ADDRESS	CITY/STATE	*ZIP CODE*

I have an alternate address where I prefer mail to be sent ☐ Yes ☐ No

PREFERRED MAILING ADDRESS	CITY/STATE	*ZIP CODE*

COUNTY	BIRTH STATE/COUNTRY	SOCIAL SECURITY NUMBER

MAIN PHONE NUMBER	OTHER PHONE NUMBER
☐ Home Phone ☐ Mobile Phone	☐ Home Phone ☐ Mobile Phone

Legacy sends appointment reminders/communications via text. By checking this box, I indicate that I DO NOT WANT any text communications (opting out) ☐ Opting Out **Initials:** _____

EMAIL ADDRESS (this is required for access to the patient portal, called MyChart)

MARITAL STATUS

☐ Single ☐ Married ☐ Living with Domestic Partner ☐ Divorced ☐ Other:

SEX (AT BIRTH)

What sex were you assigned at birth? (on your original birth certificate) ☐ Male ☐ Female

LEGAL SEX

What sex is shown on your driver's license or other identification? ☐ Male ☐ Female

Patients 18 years old and up only, please answer the following questions:

1: **Sexual orientation** is the term used to describe what gender(s) someone is sexually and/or romantically attracted to.

2: **Gender Identity** is how we feel about and express our gender and gender roles — clothing, behavior, and personal appearance. It can be a feeling that we have as early as age two or three.

SEXUAL ORIENTATION

☐ Lesbian or Gay ☐ Bisexual ☐ Don't Know
☐ Straight or heterosexual (not lesbian or gay) ☐ Something else ☐ Decline to Answer

CURRENT GENDER IDENTITY

What is your current gender identity?

☐ Male ☐ Transgender Male / Female to Male ☐ Other ☐ Decline to Answer
☐ Female ☐ Transgender Female / Male to Female ☐ Genderqueer (neither exclusively male nor female)

OCCUPATION	***FAMILY SIZE (# of persons living in your home)***	***TOTAL FAMILY HOUSEHOLD INCOME***
		☐ Yearly ☐ Monthly

PREFERRED METHOD OF CONTACT (Legacy may use any method listed below when necessary to contact you)

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Letter ☐ Patient Portal - MyChart ☐ Email

HOMELESS?	**LIVING IN A RESIDENT GROUP HOME?**	**EMPLOYED IN HEALTHCARE?**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

AGRICULTURAL WORKER	***U.S. MILITARY VETERAN***
☐ Yes ☐ No If yes: ☐ Seasonal ☐ Employed Year-Round ☐ Retired	☐ Yes ☐ No

ETHNICITY

☐ Hispanic ☐ Non-Hispanic ☐ Declined to State

RACE (if multi-racial, choose all that apply)

☐ Asian ☐ Other Pacific Islander ☐ White ☐ Choose Not to Disclose
☐ Native Hawaiian ☐ American Indian/Alaska Native ☐ Black/African American

PREFERRED LANGUAGE (SPOKEN)

☐ English ☐ Spanish ☐ Vietnamese ☐ Other:

PREFERRED LANGUAGE (WRITTEN)

☐ English ☐ Spanish ☐ Vietnamese ☐ Other:

ENGLISH FLUENCY / FORM CONFIDENCE

☐ Good ☐ Not Good ☐ Not at All ☐ Very Good ☐ Interpreter Needed

HOW DID YOU LEARN ABOUT OUR SERVICES?

☐ Print Ad ☐ Billboard ☐ Radio/TV Ad ☐ Internet Search or App ☐ Event ☐ Friend/Relative
☐ Other: ☐ Referral Name of referral source:

EMERGENCY CONTACT NAME	**RELATIONSHIP TO PATIENT**	**PHONE NUMBER**

ADDRESS	**CITY/STATE**	**ZIP**	**COUNTY**

Does this person know that you are a patient of Legacy Community Health? ☐ Yes ☐ No

OTHER CONTACTS	CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER	SAME AS EMERGENCY CONTACT	N/A
Primary Legal Guardian is the court-appointed person to make health care decisions in place of the patient. Appropriate documentation must be provided.					
Primary Legal Guardian				☐	☐
Primary Caregiver is the person responsible for providing day-to-day care for the patient.					
Primary Caregiver				☐	☐
Medical Power of Attorney is the patient-appointed person to make health care decisions in place of the patient if the patient is unable to make decisions on their own.					
Power of Attorney				☐	☐
Delegated Individual for communication is the patient-appointed person to communicate with about my health care, which may include information about my medical diagnosis, eligibility status and appointments.					
Delegated Individual				☐	☐

PREFERRED PHARMACY

☐ Legacy Pharmacy – Lyons ☐ Legacy Pharmacy – Montrose ☐ Legacy Pharmacy – Sharpstown

☐ If Other: Phone: Address: City/State: ZIP: County:

DO YOU HAVE ANY HEALTH CARE DIRECTIVES?

☐ Yes ☐ No ☐ Medical Power of Attorney ☐ Directives to Physician and Family (Living Will)

DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE MEDICAID, MEDICARE, CHIP, V.A., OR OTHER INSURANCE COVERAGE?

☐ Yes ☐ No If yes, who? | Have you applied in the last 30 days? ☐ Yes ☐ No

PARENT/LEGAL GUARDIAN NAME (IF PATIENT UNDER 18)	RELATIONSHIP TO PATIENT

FINANCIAL GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR ANY FEES DUE)

(☐ If same as Patient Information, check box and skip to Policy Holder Information)

NAME			SOCIAL SECURITY NUMBER
ADDRESS	**CITY/STATE**	**ZIP**	**COUNTY**
DATE OF BIRTH	**EMAIL ADDRESS**		
MAIN PHONE NUMBER		**OTHER PHONE NUMBER**	
☐ Home Phone ☐ Mobile Phone		☐ Home Phone ☐ Mobile Phone	
EMPLOYMENT STATUS			
☐ Part-Time ☐ Full-time ☐ Not Employed			

POLICY HOLDER INFORMATION

(☐ If same as Patient, check box, and skip to Insurance Information)

NAME			SOCIAL SECURITY NUMBER
ADDRESS	**CITY/STATE**	**ZIP**	**COUNTY**
DATE OF BIRTH	**PATIENT'S RELATIONSHIP TO INSURED/POLICY HOLDER**		
	☐ Spouse ☐ Parent/Guardian ☐ Other:		
MAIN PHONE NUMBER		**OTHER PHONE NUMBER**	
☐ Home Phone ☐ Mobile Phone		☐ Home Phone ☐ Mobile Phone	

INSURANCE INFORMATION

WHAT TYPE OF INSURANCE DO YOU HAVE?

☐ None / Self Pay ☐ Other ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance (HMO/PPO)

Member Insured ID number: _____ Group Number: _____

Private Insurance Plan Name: _____ PCP Provider if HMO Policy: _____

EMPLOYER INFORMATION

EMPLOYER COMPANY NAME			PHONE NUMBER
ADDRESS	**CITY/STATE**	**ZIP**	**COUNTY**

OFFICE USE ONLY PATIENT ID NUMBER	