Keystone Rural Health Consortia, Inc. Patient Profile **Requested Provider: ____________________________**

First Name: ____________________________ Middle: __________ Last Name: ________________ **DOB**: _________ **SSN:** ________________

Phone: Home ________ Cell ________ Work ________ Email: ___________________________________

Street Address: ________________________________ P.O. Box ____________________ City: __________________State: __________ Zip: _________

Sex at Birth: Male _____ Female ______ **Preferred Pharmacy:** _______________________

Gender Identity: Male ____ Female ____ Transgender Male-Female ____ Transgender Female-Male _____Other _____ Choose Not to Disclose _____

Sexual Orientation: Lesbian/Gay _____ Straight _____ Bisexual _____ Something Else _____ Don't Know _____ Choose Not to Disclose _____

Race: ( ) Asian ( ) Native Hawaiian ( ) Other Pacific Islander ( ) Black/African American

( ) American Indian/Alaskan Native ( ) White ( ) Refused to Report

Do you use tobacco? ( ) Yes ( ) No If Yes Specify: Type __________ Frequency: ______

Residence Status: ( ) Lives in own home/apartment ( ) Temporary: Please Specify _______________

Homeless: ( ) Shelter ( ) Transitional Housing ( ) Double Up ( ) Street

Ethnicity: ( ) Hispanic/Latino ( ) Non-Hispanic/Latino ( ) Refused to Report

Preferred Language: ________________ **Secondary Language**: ______________________

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed **Are you a Veteran?** ( ) Yes Specify: __________ ( ) No

Emergency Contact(s): __________________________ Phone: _______________________ Relationship: ___________________

Patient Employment: ( ) Employed ( ) Retired ( ) Unemployed ( ) Student ( ) Other

Name of Employer: ______________________ Employer Phone: _________________________

Approximate Yearly Income: (For Grant Reporting Purposes Only)

( ) $0-10,000 ( ) 30,001-50,000 ( ) 70,001-90,000

( ) 10,001-30,000 ( ) 50,001-70,000 ( ) 90,001-110,000 ( ) 110,000+

Number of People in Household: _____________

Guarantor: (PERSON RESPONSIBLE FOR BILL) ( ) Same as Patient ( ) Responsible Party

Name: ______________________ Address: ______________________ City/State: ______________SSN: ________________ DOB: ____________

Employer: ______________________ Employer Phone: _______________________

Primary Insurance: (Patient's Insurance Card Information)

( ) Same as Patient ( ) Same as Guarantor ( ) Other **Copay Amount: ______________ Relationship to Insured/Guarantor: ___________**

Insured Party: _________________ Inured Phone: _____________ SS#: ____________________

Insurance Company: ___________________ Insured ID: _____________ Policy/Group #: _________

Address: ___________________________ City/State: _______________ Date of birth: ___________

Secondary Insurance:

( ) Same as Patient ( ) Same as Guarantor ( ) Other **Copay Amount: ______________ Relationship to Insured/Guarantor: ___________**

Insured Party: _________________ Inured Phone: _____________ SS#: ____________________

Insurance Company: ___________________ Insured ID: _____________ Policy/Group #: _________

Address: ___________________________ City/State: _______________ Date of birth: ___________