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: _____