Patient Questionnaire

Patient Name: ______________________________Date of Birth_______________
Provider Name: __________________________________

We must collect statistics on all the patients we serve because we receive Federal grant funds. Your personal information will be held in the strictest of confidence and is only reported in aggregate form. You have the right to refuse to give this information, however, it may limit the services or programs we are able to deliver to you.

Need affordable Health Insurance or Dental Care? We can help!

1.We assist the uninsured & underinsured obtain health insurance; such as, enrollment in the Market Place Plans or Dental Care.
Please indicate which you have interest in.

Health Insurance _______________ Dental Care ________________

2. Is English your primary language? _____Yes ____No
If no, what language are you best served in?
(This includes sign language or the need for TTY device). ____________________

3. Are you homeless or doubling up with another household or have you been at anytime during this calendar year? ____Yes ____No

4. Are you a Seasonal Agricultural Worker or Migrant Farmer? ____Yes ____No

5. Are you active military? _____Yes _____No Are you a veteran? _____Yes _____No

6. Are you employed? _____Yes _____No Full/Part Student? ____Yes ____No Full/Part

7. Are you Retired? ____Yes ____No Are you Disabled? ____Yes ____No

8. MyCare offers a Patient Portal where patients can enroll by email to download lab results, request medication refills, pay bills online and much more. Please share your email address if you are interested in using or learning more about this service.
____________________________________@____________________.

9. Would you like information on Advance Directives? _____Yes _____No

10. How did you hear about MyCare? ___ Friend/Family ___ Social Media ___ Community Organization ___ Insurance Company ___ Hosp/ ER/ Urgent Care ___ Another MyCare Service ___ Community Event

Total Annual Family Income.

How Many members in your household? __________ What is your approximate annual income? ___________________

Identity (Please check if applicable)	√
Are you Hispanic or Latino?	

Race (Please check appropriate box)	√
Asian	
Native Hawaiian	
Other Pacific Islander	
Black African American	
American Indian/Alaska native	
White	
More than one race	

Sexual Orientation and Gender Identity (Please circle appropriate)

Lesbian	Gay	Bisexual	Queer	Straight	Questioning	Something else	Decline to answer
Male	Female	Trans Male	Trans Female	Genderqueer	Something else	Decline to answer	

Patient Signature: ______________________________________ Date: __________________