

NAME: _____
Nombre: (Last) (First) (Middle)
Apellido Primer Nombre Segundo Nombre

SS#: _____ **Date of Birth:** _____ **Age:** _____ **Female** _____ **Male** _____
Seguro social Fecha de nacimiento Edad Hembra Varón

Address: _____
Dirección (Street) (City) (State) (Zip code)
Calle Ciudad Estado Código postal

Telephone Number: _____
Numero de teléfono (Home) (Work) (Mobile)
Casa Trabajo Celular

Emergency Contact Person: _____ **Telephone Number:** _____

Relationship: _____

Race: (*Circle one*) Caucasian Black/African Asian Hispanic/Latino Multi-Racial Native American Other

Language Spoken in the home: _____

Household Income: *Circle One (Circule uno)*
 (\$0 to 9,999) (\$10,000 to 14,999) (\$15,000 to 24,999) (25,000 to 34,999) (35,000 to 49,999) (50,000 +)

Do you have a Primary Care Doctor? _____ Physician Name: _____
Tiene un medico de cabecera? Nombre del medico/doctor

Do you have a dentist? _____ Dentist Name _____
Quien es el dentista? Nombre del dentista?

How many times have you been to the emergency room in the past 12 months? _____

Have you ever been hospitalized? _____ Reason: _____
Alguna vez ha sido hospitalizado? Razon

How many times have you been hospitalized over the past year? _____

Do you have health insurance? Yes No
Tiene seguro medico?

Please circle (*Circule uno*) Private (*Privado*) Medicaid None

Where did you hear about Care Ring's clinic? Circle one, and please be specific where appropriate.

- | | | |
|--------------------------------------------------|-----------------------------|---------------------------------------------------|
| 1. Private healthcare provider Specify: _____ | 4. Health Department | 7. Media (newspaper, TV, radio) Specify: _____ |
| 2. Hospital Specify: _____ | 5. Family or Friend | 8. Other: _____ |
| 3. Other clinic Specify: _____ | 6. School Specify: _____ | |