Premier Community HealthCare Group, Inc.
Patient Information Form

Patient Information

1. Name _____Date of Birth:_____
2. Mailing Address: _____ Physical Address: _____
3. City:_____ State: _____ Zip Code: _____
4. Home Phone: _____ Cell Phone: _____ Work Phone: _____

   Preferred Phone: □ Home □ Mobile □ Work

   Preferred Method of Appointment Reminders: □ Voice □ Text □ Email □ Do Not Contact
5. E-mail Address: _____
6. Marital Status: □ Single □ Married □ Divorced □ Widowed
7. Gender: □ Female □ Male Are you disabled? □ Yes □ No

Questions 8 & 9 are not required for patients less than 18 years of age.

Collecting gender identity and sexual orientation data is important to help reduce health disparities and promoting culturally competent care in health centers.

8. Sexual Orientation (a person's sexual identity in relation to the gender to which they are attracted)

   □Lesbian/Gay □Straight (not lesbian/gay) □Bisexual

   □Other_____ □Don't Know □Choose not to disclose
9. Gender Identity (a person's perception of having a particular gender, which may or may not correspond to the gender they were at birth.)

   □Male □Female □Transgender Male(Female-to-Male)

   □Transgender Female(Male-to-Female) □Other _____ □Choose not to disclose
10. Race: □ White □ Black □ Am. Indian/Alaskan Native □Native Hawaiian □Other Pacific Islander

    □ Asian □More than one race
11. Ethnicity: □ Hispanic/Latino □Not Hispanic/Latino Preferred Language:_____
12. Employment Status: □Employed □Self Employed □Unemployed □Disabled

    □Retired □Full Time Student □Part Time Student Employer/School Name:_____
13. Are you a military veteran? □Yes □No Military Discharged? □Yes □No Discharge Date: _____
14. Check living arrangements: □Own/Rent □Shelter □Homeless □Public Housing

    □Living with friend/doubling up □Street/Car □Transitional □Other _____
15. Do you have health insurance? □Yes □No If yes, name of insurance?_____
16. Do you have internet access? □Yes □No
17. Parent/Legal Guardian Information: (complete only if patient is a minor)

    Mother's Name:_____ Date of Birth:_____ Gender: □Male □Female

    Father's Name: _____ Date of Birth:_____ Gender: □Male □Female

    Guardian's Name:_____ Date of Birth:_____ Gender: □Male □Female
18. Phone Number: _____ E-mail Address: _____
19. Marital Status: □ Single □ Married □ Divorced □ Widowed
20. Race : □White □ Black □Am. Indian/Alaskan Native □Native Hawaiian

    □Other Pacific Islander □Asian □More than one race
21. Employment Status: □Employed □Self Employed □Unemployed □Disabled □Retired

    □Full Time Student □Part Time Student Employer/School Name:_____

Premier Community HealthCare Group, Inc.
Patient Information Form

22. In the past two years, or prior to retirement or disability:

- Have you or the head of your household worked in agriculture? □Yes □No
- Did you or the head of your household move from this area to another County or State in search of agricultural work? □Yes □No
- Has your family lived in this area and earned more than half their income from seasonal agriculture? □Yes □No

23. Are you a refugee? □Yes □No Country of Origin:_____

24. Circle your household size and annual household income range. *Information for reporting purposes only.*

Household Size	Annual Household Income				
1	$0 - $ 12,060	$12,061 - $16,040	$16,041 - $20,020	$20,021 - $24,120	$24,121 and up
2	$0 - $ 16,240	$16,241 - $21,599	$21,600 - $26,958	$26,959 - $32,480	$32,481 and up
3	$0 - $ 20,420	$20,421 - $27,159	$27,160 - $33,897	$33,898 - $40,840	$40,841 and up
4	$0 - $ 24,600	$24,601 - $32,718	$32,719 -$40,836	$40,837 - $49,200	$49,201 and up
5	$0 - $ 28,780	$28,781 - $38,277	$38,278 - $47,775	$47,776 - $57,560	$57,561 and up
6	$0 - $ 32,960	$32,961 - $43,837	$43,838 - $54,714	$54,715 - $65,920	$65,921 and up
7	$0 - $ 37,140	$37,141 - $49,396	$49,397 - $61,652	$61,653 - $74,280	$74,281 and up
8	$0 - $ 41,320	$41,321 - $54,956	$54,957 - $68,591	$68,592 - $82,640	$82,641 and up

25. Premier participates in the 340B Drug Pricing Program. This program is a U.S. federal government program that requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

Premier patients can opt to have prescriptions prescribed by Premier providers filled under this program by using one of the following pharmacies. By doing so this will allow you to receive a reduced price for qualified prescriptions.

□ Walgreens #04811–12807 US Hwy 301, Dade City
□ Walgreens #05414 – 9220 Little Rd, New Port Richey
□ Walgreens #05604 – 6429 Gall Blvd, Zephyrhills
□ Walgreens #06412–28115 SR 54, Wesley Chapel
□ Walgreens #11790 – 36515 SR 54, Zephyrhills
□ Walgreens #12318 – 2480 US Hwy 19, Holiday
□ Walgreens #0440 – 8951 Hudson Ave, Hudson
□ Walgreens #03629 – 12028 Majestic Blvd, Hudson
□ Walgreens #03836 – 9332 US Hwy 19, Port Richey
□ Walgreens #05857 – 740 SR 54, New Port Richey
□ Walgreens #07020-Massachusetts Ave, New Port Richey
□ Walgreens #07466 – 14217 US Hwy 19, Hudson
□ Walgreens #16262 – 105 Mariner Blvd, Spring Hill

Please check pharmacy above or list the pharmacy preferred: _____

Address: _____ Phone: _____

_____ _____
Patient's Signature **Date**

_____ _____ _____
Signature of Parent or Patient's Representative (if applicable) **Date** **Relationship to Patient**

Office Use Only

Care Team Member Signature: _____ **Date:** _____