New Consumer Form

Date: _____ **Chart #:** _____ **Age:** _____

Special Health Resources for Texas, Inc. (SHRT) is a Community Health Center and all information requested is for statistical purposes. All information is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent. The information requested allows SHRT to evaluate each client for eligibility for our programs; therefore, we request you complete this document in its entirety.

Name	**Preferred Name (If Applicable)**

Address	**City / State**	**Zip Code**	**County**

Main Phone Number	**Other Phone Number**	**Email Address**	**Date Of Birth**

Preferred Method(s) Of Contact		
Telephone: ☐Yes ☐No [Okay to leave a message: ☐Yes ☐No]	Mail: ☐Yes ☐No	☐No Contact

Marital Status	**Sexual Orientation**
☐Single ☐Married ☐Living with Domestic Partner ☐Divorced ☐ Widow ☐Other	☐Heterosexual ☐Homosexual ☐ Bisexual

Gender	**Transgender**	**Social Security**	**Birth State/Country**	**Driver's License #**
☐Male ☐Female	☐Yes ☐No			

Preferred Language	**Race**		
☐English ☐Spanish ☐Other :	☐White ☐Am. Indian/Alaska Native ☐Asian	☐Black/African American ☐Pacific Islander ☐Multiracial	☐Hawaiian ☐Other

Ethnicity	**Homeless**	**Agriculture Worker**	**Us Military Veteran**
☐Hispanic ☐Non-Hispanic	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Family Size (# Of Persons Living In Your Home)	**Total Family Household Income**

Please provide your emergency contact information below.

Name	**Relationship**	**Phone Number**	**Address**
Does this person know that you are a patient of SHRT? ☐Yes ☐No			

Primary Caregiver

(Person responsible for providing day-to-day care for the patient. Appropriate documentation must be provided.)

	Name	**Relationship**	**Phone Number**
☐N/A, I Do Not Have A Primary Caregiver ☐Same As Emergency Contact			

Legal Guardian

(Court appointed person to make healthcare decisions in place of patient. Appropriate documentation must be provided.)

	Name	**Relationship**	**Phone Number**
☐N/A, I do not have a legal guardian ☐Same as emergency contact			

Health Care Proxy

(Person patient appoints to make healthcare decisions in their place. Appropriate documentation must be provided)

	Name	**Relationship**	**Phone Number**
☐N/A, I do not have a Health Care Proxy ☐Same as emergency contact			

Name: _____

Medical Information

Name Of Primary Care Provider	Address	Phone Number
Name Of Preferred Pharmacy	**Address**	**Phone Number**

Do You Have Any Advanced Directives?	
☐No	☐Yes, Do Not Resuscitate Medical Power of Attorney Living Will
Maternity Patients Only	
☐N/A	For your current pregnancy, in what month of your pregnancy did you first receive care? Did you receive this care from SHRT? ☐Yes ☐No

Complete the insurance questions below

Do You Or Anyone In Your Household Have Medicaid, Medicare, Chip, V.A., Or Other Insurance Coverage?

☐Yes ☐No If yes, who?

What Type Of Health Insurance Do You Have?

☐None / Self Pay ☐Military ☐Medicare Plan ☐Medicaid Plan ☐Private Insurance

Plan #: _____ Group#: _____

Private Insurance Company: _____

PCP Provider if HMO Policy: _____

Insured/Policy Holder's Information	Insured Employer's Information
Name:_____ Date of Birth (mm/dd/yyyy)_____ Social Security #: _____	Name:_____ Address: _____ _____ Phone: _(____)_____-_____

Marketing

How Did You Learn About Our Services?
☐Friend/Relative ☐In Print ☐On Radio/TV ☐Internet ☐Referral ☐Community Event ☐Other

By signing this form, I attest that all the statements I have made, including my answers to all questions are true and correct to the best of my knowledge and belief. I agree to give the eligibility staff any information necessary to prove statements about my eligibility. I understand that giving false information could result in disqualification and repayment. Should my income or number of people in my family change, I will tell the eligibility staff.

_____ _____

Signature of Client or Parent / Guardian or Power of Attorney Date

_____ _____

Signature of Person Who Helped Complete this Form Date