ST. CROIX COUNTY Wisconsin
Innovation Through Cooperation
Public Health

PATIENT INFORMATION FORM

Date: _____

Name: _____
Last First M Maiden Preferred Name

Address: _____
Street City Zip

Sex: _____ Female _____ Male Date of Birth: _____/_____/_____

Check best way(s) to contact you:

_____ Cell phone: _____ Home phone: _____
_____ Text cell
_____ Email: _____
_____ Write home

Emergency Contact Person: _____
Name Phone Relationship

Race:
_____ White
_____ Black/African American
_____ American Indian
_____ Asian
_____ Hawaiian/Pacific Islander
_____ Other

Gender identity:
_____ Female
_____ Male
_____ Transgender
_____ Transsexual
_____ Other

Are you of Hispanic/Latino origin?
_____ Yes
_____ No

Are you a student?
_____ Yes, _____ (where)
_____ No

Are you limited in English proficiency?
_____ Yes
_____ No

Marital status:
_____ Married
_____ Single
_____ Divorced/Separated
_____ Widowed

Do you have health insurance? ____ Yes ____ No
Do you have Forward Health (Badgercare/FPOS)? ____ Yes ____ No ID No: _____
Do you have a primary health care provider? ____ Yes ____ No
Are you under the age of 22 with a chronic illness? ____ Yes ____ No
Do you receive Supplemental Security Income (SSI)? ____ Yes ____ No
Social Security No: _____

Your monthly or annual income (before taxes): _____
Number you support with this income: _____

How did you hear about our service? _____

(Office Use Only)

Is Patient a Confidential Contact? _____ Yes _____ No Patient #: _____

Revised 09/2018