COMMUNITY HEALTH CENTER OF LUBBOCK
CARING FOR LUBBOCK

CONFIDENTIAL ENROLLMENT FORM

Please have your check stubs, social security, insurance card, and immunization cards ready. **Failure to disclose insurance and financial information or declination of assistance would mean paying 100% of your bill at CHCL.**

PATIENT DEMOGRAPHICS

Patient Name: _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary

Gender Identity: □Male □Female □Transgender M to F □Transgender F to M □Other

Sex At Birth: □ Female □ Male

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Mailing Address/PO Box: _____ Cell Phone: _____

City: _____ Home Phone: _____

State, Zip: _____ Work Phone: _____

Emergency Contact: _____ Email: _____

Relationship: _____ Phone: _____

GENERAL INFORMATION

Marital Status
□ Single
□ Married
□ Divorced
□ Widowed
□ Separated

Preferred Language
□ English
□ Spanish
Other:

Race
□ White
□ Black
□ Asian
Other:

Ethnicity
□ Not Hispanic
□ Hispanic /Latino
Other:

Veteran
□ Yes
□ No
Farmworker Status
□ None
□ Migrant
□ Seasonal

Housing Status
□ Own
□ Rent
□ Public Housing
□ Shelter
□ With Others
□ Street

Employment Status
□ Disabled
□ Full Time
□ Part Time
□ Retired
□ None
□ Student

INSURANCE COVERAGE

□ Medicaid / CHIP □ Medicare/ Medicare Replacement □ Healthy Texas Women □ None

□ Private Medical Insurance □ Private Dental Insurance □ UMC Blue Card

Policy Holder information (If Not Patient): Relationship: _____

Name: _____ DOB: _____ SSN: _____

GUARANTOR □ SELF
(OR Complete below for MINORS)

First Name: _____ Last: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

HOUSEHOLD SIZE & INCOME

_____ **Family Size (Immediate Family)** _____ **# Dependents (Under 18 yrs)**

	Income Source	How Often	Amount Per Pay Period	Person Receiving
1				
2				
3				

TB (Tuberculosis) Assessment

□Yes □No Have you had a cough lasting more than three (3)weeks in the last six months with at least one of the following symptoms: (Check off symptom(s) below)

□ Bloody sputum □ Night sweats □ Weight loss □ Fever

For Clinic Use Only :

Does patient have a positive questionnaire? □ No □ Yes (PSR to initial here if yes: _____)

Nursing staff notified by PSR: _____ Patient assessed by staff? □ No □ Yes (Staff Initials: ___)

Action(s) taken: _____

All the above information is true and correct. ***Signature:*** _____ ***Date:*** _____

ADDITIONAL FAMILY MEMBERS / PATIENT DEMOGRAPHICS

Family = Spouse (including unmarried mutual parent) &/or legally supported dependents under the age of 18, in the same household.

1 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

2 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

3 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

4 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

5 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

6 **Name:** _____ **Social Security #:** _____ **DOB:** _____

Legal Sex: □ Female □ Male □ Nonbinary **Gender Identity:** □Male □Female

Sex At Birth: □ Female □ Male □Transgender M to F □Transgender F to M □Other

Sexual Orientation: □Heterosexual □Lesbian/Gay □ Bisexual

Insured □ Yes (Please provide a copy to staff) □ No **Relationship:**

Community Health Center of Lubbock
LEARNING ASSESSMENT
EVALUACIÓN DE APRENDIZAJE

In order to give you the best possible care, we need to know about you/or your caregiver and how you/they learn. The following information and questions will help us to help you learn about taking care of yourself.
Para darle el cuidado mejor posible, tenemos que saber como usted, o la persona responsable por su cuidado, aprende. La información y las preguntas siguientse nos ayudarán a ayudarle a usted aprender como cuidarse.

The following information pertains to Patient or Caregiver
La información siguiente pertenece al Paciente o la persona responsable por su cuidado

Patient and/or Caregivers Name: _____ Phone# _____ Date _____
Paciente y/o Nombre de persona responsable _____ *Teléfono* _____ *Fecha* _____

How do you like to learn new things? (check all that apply)
¿Cómo le gusta aprender cosas nuevas? (marque todas que aplican)

	Reading *(Leer)*		Audiotapes *(Cintas gravadas)*
	Discussion (Discusión)		Pictures/Diagrams (*Retratos/ Diagramas)*
	Videotapes *(Videocintas)*		Hands on/Demonstration *(Practicando/Demostración)*
	Classroom Instruction *(Istrucción en clase)*		Self-Study *(Autoestudio)*

Factors which affect learning: *(Los factores que afectan el aprendizaje)*

	Yes *(Sí)*	No *(No)*	Comments *(Comentarios)*
Do you speak English in your home? ¿Habla usted inglés en su casa?			If no, what language? *(¿Si no, qué idioma?)* Name of Interpreter: *(Nombre de Intérprete:)* Phone # (*Teléfono)*
Can you read English? *(¿Puede usted leer inglés?)*			
Do you write English? *(¿Escribe usted inglés?)*			
Are you happy with your reading ability? *¿Esta Usted contento(a) con su capacidad de leer?*			If no, why not? *(¿Si no, por qué no?)*
Can you hear well? *(¿Puede usted oír bien?)*			
Do you see well? *(¿Ve usted bien?)*			
Do you have any cultural or religious practice/ beliefs that may affect your care or treatment? *(¿Tiene usted alguna práctica cultural o religiosa/creencias que pueden afectar su cuidado o tratamiento?)*			
Other factors: *(Otros factores)*			
Last grade completed? *(¿Último grado completado?)*			

Please let us know, at any time, if you don't understand any of the information we are giving you. We want to work with you to make it easy for you to understand.
(Por favor avísenos, en cualquier momento, si usted no entiende alguna de la información que le demos. Queremos trabajar con usted para hacer fácil que usted pueda entender).

Nonmedical Service Needs Screening

This screening tool asks questions about nonmedical needs that impact a person's opportunity to be healthy like having enough food, reliable transportation, and a safe place to live. You do not have to answer these questions, but your answers will help Community Health Center of Lubbock to work on a plan to connect you to available services if you would like any assistance. This screening should take a few minutes.

If English is not your first language, please see front desk for an interpreter who will assist you at no cost.

I do not want to answer these questions ☐

Nonmedical Service Needs Screening				
	**Food**	***Having enough food plays an important role in your health, so we are asking questions about food.***		
	Please answer whether the next two statements were Often, Sometimes, or Never true for you and your household. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true ☐	Sometimes true ☐	Never true ☐
	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true ☐	Sometimes true ☐	Never true ☐
	**Transportation**	***Having reliable transportation plays an important role in your health, so we are asking questions about transportation.***		
	Within the past 12 months, has lack of reliable transportation kept you from medical appointments or getting medications?	Yes ☐	No ☐	
	Within the past 12 months, has lack of reliable transportation kept you from doing things needed for daily living (grocery shopping, working?	Yes ☐	No ☐	
	**Housing**	***Having a steady place to live plays an important role in your health, so we are asking questions about where you live.***		

	What is your living situation today?	I have a steady place to live ☐	I have a steady place to live today, but I'm worried about losing it in the future ☐	I do not have a steady place to live ☐ (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in the woods, in a car, abandoned building, bus or train station, or in a park)
	Think about the place you live. Do you have problems with or paying for utilities (electricity, gas, heat, water)?	Yes ☐	No ☐	
	**Family and Community Support**	***Having supports in your life plays an important role in your health, so we are asking questions about childcare.***		
	Do you need help finding childcare for your child (or children)?	Yes ☐	No ☐	
	If you have current childcare, is it reliable, consistent care?	Yes ☐	No ☐	
	**Employment**	**Having steady income from employment in your family plays an important role in your health, so we are asking questions about employment.**		
	Do you have a full-time job? (Greater than 30 hours a week or 130 hours a month)	Yes ☐	No ☐	If No, would you like help finding employment? Yes ☐ No ☐ Maybe Later ☐