Healing Hands Resource Center

Safe Place Clinics
Integrated Health Services

Demographic Information /Referral Source Form

Name: DOB: Medicaid No.:

Gender: Male [ ] Female [ ]

Address: _____

Ph: _____

Emergency Contact Name _____Emergency Contact Ph:_____

Date Of Initial Contact:

Referred by : Self Referral [ ] Provider: Name _____[ ] Insurance [ ] Other [ ]

Name of Primary Care Physician _____ Ph:_____ Date of Last exam ___

Marital status: Married [ ] Never Married [ ] Divorced [ ] Separated [ ]

Widowed [ ] Civil Union [ ]

Primary Method of Communication: Verbal [ ] Written [ ] Sign Language [ ]

Primary Language: Interpreter Services Needed : Yes [ ] No [ ]

Additional Accommodation other than verbal English communication: _____ None needed [ ]

Consumer Third Party Payor : Yes [ ] No [ ]