

Thank you for completing/reviewing this form. Your (voluntary) participation helps us better understand our patients and fulfill our mission as a community health center.

Date:

	GENER	RAL INFORMATIO	N (Fill out for self/pati	ient)	
Patient Legal First Name:	Last Name:		Preferred Name:		Date of Birth (patient):
1a. What is your (patient's) preferred language?		1b. Do you (patient) need an interpreter? □ Yes □ No			
	HOUSING / I	NCOME (Fill out b	ased on household inf	formation)	
2. How many people are in your	3. What	What is your annual household income (total combined for you and your household)?			
nousehold, including yourself?	Dependi	Depending on your income, you may be eligible for assistance. \$			
	□ \$0-14	,500	□ \$24,001-29,000	□\$	44,001-59,000
	□ \$14,5	01-19,000	□ \$29,001-34,000	□\$	59,001-75,000
	□ \$19,0	01-24,000	□ \$34,001-44,000	□\$	75,001+
4. What is your housing situation today? I have steady housing			□ Own	🗆 Rent	
do not have steady housing:					
Doubling Up (Couch Surfing)		Homeless Shelter		🗆 Street /	Park / Car
		Transitional (Recovery Home)		🗆 Other	
. At any time in the past 2 years	, has seasonal/	migratory farm wo	ork been your or your	family's mair	source of income?
5. Are you (patient) a United Sta	ates Armed For	rces veteran?	Yes 🗆 No		
	DEMOGR	APHIC INFORMAT	TION (Fill out for self/p	oatient)	
'. What are your (patient's) pro	nouns?				
∃ He/him/his		□ She/her/hers	Other		
Preferred name		□ They/them/the	eirs		
. What is your (patient's) sex a	ssigned at birth	h?			
. What is your (patient's) curre	nt Gender Ider	ntity? (We will use	this for your medical	records.)	
0. How would you (patient) de	scribe your Sex	kual Orientation?			
 11. Are you (patient) Hispanic and/or Latinx? □ Another Hispanic, Latinx or Spanish Origin □ Cuban 		-	kican American, Chica ic, Latinx or Spanish C		Puerto Rican
			lack/African Amorican (Chinese Filinin	
2. Describe your (patient) racia	l background.	<u>(American Indian, B</u>	<u>ack/Ajrican American, c</u>	ennese, rinpin	o, Japanese, Mam, White, etc.)

OFFICE USE ONLY	Completed By:	MRN:

Patient Demographic Questionnaire



You may wonder why we need this information. North Olympic Healthcare Network is a **Federally Qualified Health Center (FQHC)**, a special type of community health center. We offer care to everyone, regardless of age, gender, race, or whether a patient has insurance or can afford to pay.

Your answers on this form help us:

- Understand our patients' social, emotional, and financial needs
- Identify who may benefit from assistance
- Provide high-quality, personalized care
- Fulfill our mission as a community health center
- Meet our reporting requirements as an FQHC

Your Answers Are Secure

We keep your answers private and secure. We only report them in a way that does not identify individuals.

How to fill out the PDQ

Please read each question carefully and answer as best you can.

If you are filling out the form on behalf of another person (spouse, child, etc.):

- Please complete the *General Information* and *Demographic Information* sections based on the patient's information.
- Please complete the *Housing/Income* section based on the patient's household information.

Reviewing the PDQ Each Year

Once each year we will ask you to review the information on this form.

If there are no changes, please initial and date in the space at the bottom of the form.

If you need to make changes, please put a line through the previous answer and fill in the check box of the new, corrected answer. Then initial and date in the space at the bottom of the form.

Thank you for choosing North Olympic Healthcare Network for your healthcare needs!