Finger Lakes COMMUNITY HEALTH
Taking the time to care.

Patient Information			
Last Name:	First Name:	Middle Initial:	Today's Date:
Date of Birth:	Sex at Birth:	Social Security:	Marital Status:

Mailing Address (Mail can be sent here)		
Address:		Apt, Suite, Lot#:
City:	State:	Zip Code:

Physical Address (Where you live, if different from mailing address)		
Address:		Apt, Suite, Lot#:
City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:

Email Address: ____

By providing your email address, you agree to be signed up to the online patient portal, which will allow you to view your Finger Lakes Community Health medical record, as well as having the ability to communicate electronically with your Finger Lakes Community Health provider.

Contact Method: ☐ **Do Not** Contact Me By Mail ☐ Contact by Mail ☐ Phone ☐ Text Message ☐ Email

Work Status: ☐ Full time ☐ Part time ☐ Self-employed ☐ Not employed ☐ Active Duty ☐ Retired

Employer Name, City, and State (if employed):

Veteran Status: ☐ I am a veteran ☐ I am not a veteran

Student Status: ☐ Not a student ☐ Full Time ☐ Part Time Highest Grade Completed:

Preferred Pharmacy (pharmacy name and city):

Race (select all that apply):
☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Asian

Hispanic Origin: ☐ Yes ☐ No | Primary Language: ☐ English ☐ Spanish ☐ Other:

Living arrangement information:
☐ Not Homeless ☐ Homeless ☐ Doubling Up ☐ Shelter ☐ Transitional Housing ☐Treatment Facility ☐ Incarcerated ☐ Public Housing

Responsible Party Information (If different from patient)		
Name (if different from patient):		Relationship to Patient:
Address:		Apt, Suite, Lot#:
City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:	Work Phone Number:

Emergency Contact		
Name		Relationship to Patient:
Home Phone Number:	Cell Phone Number:	Work Phone Number:

For Office Use Only

Information Updated on system by:	Date: