BROOKLYN PLAZA MEDICAL CENTER, INC.
650 FULTON STREET
BROOKLYN, NY 11217
TELEPHONE (718)596-9800, FAX (718) 596-9812

HOW DO YOU HEAR ABOUT BROOKLYN PLAZA MEDICAL CENTER, INC? _____

PATIENT INFORMATION (PLEASE PRINT)

LAST: _____ **FIRST:** _____ **MIDDLE:** _____

DATE OF BIRTH: _____ **EMAIL:** _____

HOME ADDRESS: _____ **APT:** _____ **CITY:** _____ **STATE:** ____ **ZIP:** _____

PHARMACY NAME: _____ **ADDRESS:** _____

CELL PHONE: _____ ***MARITAL STATUS*: M S D** ***SEX AT BIRTH*: M F**

DO YOU HAVE A HEALTH CARE PROXY? YES ☐ NO ☐ **DO YOU HAVE A VISION IMPAIRMENT? YES ☐ NO ☐**

ARE YOU HEARING IMPAIRED? YES ☐ NO ☐

Gender Identity:
- ○ Male/Man
- ○ Female/Woman
- ○ Trans Male/Trans Man
- ○ Trans Female/Trans Woman
- ○ Gender Queer/ Gender Non-Binary
- ○ Another Gender_____
- ○ Decline to Answer

Race * Select All That Apply*
- ○ American Indian /Alaska Native
- ○ Black/ African American
- ○ White/Caucasian

Asian:
- ○ Asian Indian ○ Korean
- ○ Chinese ○ Vietnamese
- ○ Filipino ○ Other
- ○ Japanese

Native Hawaiian/Pacific Islander:
- ○ Native Hawaiian
- ○ Guamanian or Chamorro
- ○ Samoan
- ○ Other Pacific Islander

- ○ Decline to Answer

Ethnicity:
- ○ Non-Hispanic/Latino
- ○ Dominican
- ○ Cuban
- ○ Mexican, Chicano/a
- ○ Puerto Rican
- ○ OtherHispanic/Latino_____
- ○ Decline to Answer

Housing Status
- ○ Stable Housing
- ○ Living on the Street
- ○ Homeless Shelter
- ○ Transitional Housing
- ○ Pay day-to-day
- ○ Doubling Up (not paying rent)
- ○ Decline to Answer

Preferred Language:
- ○ English
- ○ Spanish/Español
- ○ French
- ○ American Sign Language (ASL)
- ○ Other
- ○ Language Interpretation: Y or N

Sexual Orientation:
- ○ Lesbian
- ○ Gay
- ○ Queer
- ○ Bisexual
- ○ Straight/Heterosexual
- ○ Don't Know
- ○ Something Else
- ○ Decline to Answer

Veteran
- ○ **Yes** ○ **No**

Migrant Worker
- ○ **Yes** ○ **No**

RESPONSIBLE PARTY FOR BILLING OTHER THAN SELF E.G. (SPOUSE, PARENT, GUARDIAN)

LAST: _____ FIRST: _____ MIDDLE: _____

SSI#: _____ RELATIONSHIP TO PATIENT: _____

HOME ADDRESS: _____APT: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: _____

WHOM CAN WE CONTACT INCASE OF AN EMERGENCY?

LAST: _____ FIRST: _____ MIDDLE: _____

HOME ADDRESS: _____APT: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER'S INFORMATION

NAME: _____ TELEPHONE #: _____

INSURANCE INFORMATION

YOUR RELATIONSHIP TO THE INSURED, CHECK ONE ☐ SELF ☐SPOUSE ☐CHILD ___OTHER SPECIFY

MEDICARE YES/NO ID# _____

MEDICAID YES/NO ID#_____

MEDICAID MANAGED CARE: YES/ NO NAME: _____ ID#:_____

PRIVATE INSURANCE: YES/NO NAME: _____ ID#:_____

POLICY# _____ GROUP#: _____

Total Combined Income for all Household Members

☐ $0 -$20,000 ☐ $20,001 - $40,000 ☐ $40,001 - $60,000 ☐ $60,001 - $100,000 ☐ $100,000 or more

PATIENT/ GUARDIAN'S SIGNATURE: _____ DATE: _____