NCCC DEMOGRAPHIC REFERRAL FORM

Referring Site:	
Referring Clinician:	
Clinician's Contact Information:	

Date:	
Full Name:	
DOB:	
SS#:	
Phone Number:	Home: Cell:
Physical Address:	Street Address ______________________________ Apt/Suite ___ City ____________________ State _______ Zip Code _______________
Mailing Address	Same as Above: ☐ Street Number/Street _____________________________________ Apt/Suite ___ City ____________________ State _______ Zip Code _______________ Can we send mail? Yes ☐ No ☐
Email:	________________________________ N/A ☐
Gender:	Male ☐ Female ☐ Other ☐ Prefer Not to Say ☐
Race:	
Ethnicity:	
Living Status:	(Independent, with spouse, with relative, residential facility, homeless, etc.)
Marital Status:	
Tobacco Use:	User ☐ Non-User ☐ Unable to Collect ☐
Smoking Status:	Current ☐ Past ☐ Never ☐
Primary Language:	(Please specify any other language than English)
Military Status:	None ☐
Employment:	Not Employed ☐ Full-Time ☐ Part-Time ☐ Actively Looking ☐
Education:	(Highest Level Completed)
Annual Household Income:	$______________ Source of Income (Child Support, Wages, Public Assistance, Disability, etc.)
Household Information:	Number of Individuals in Household: ________ Members Under the Age of 18: ________
Insurance Information:	Uninsured ☐ Medicaid: (type) ____________________ Private: __________________ (#) ___________________________

PLEASE FAX FORM TO NCCC INTAKE: (614) 267-7013 or (614) 267-7062