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:_____ (#) _____
Presenting Issue:	
If an earlier appointment becomes available, would you like us to contact you?	YES ☐ NO ☐
Do you have the ability to receive services electronically (i.e. telehealth services, video appointments, etc.)?	Yes ☐ No ☐

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

EMAIL - INTAKE@NORTHCOMMUNITY.COM