

## OPEN DOOR HEALTH CENTER RWJF Diabetes Project PATIENT INFORMATION SHEET

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Nombre) (Telefono)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Permanent or Migrant?  
(Direccion) (Ciudad) (Codigo postal) (Permanente o Migrante)

Social Security: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_  
(Seguro Social) (Fecha de nacimiento) (Apellido de soltera de su madre)

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
(Sexo) (Raza) (Etnia)

Guardian / Spouse name: \_\_\_\_\_ Guardian / Spouse phone: \_\_\_\_\_  
(Nombre de Persona encargada o su pareja) (Numero Tel. De Persona encargada o su pareja)

Guardian / Spouse address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
(Direccion de Persona encargada o su pareja) (Ciudad) (Codigo postal)

Do you have any Medicaid, Medicare or other medical insurance? Yes No  
Tiene usted Medicaid, Medicare, u otro seguro medico? Si No

Do you receive food stamps, AFDC or Section 8? Yes No  
Recibe usted cupones de alimento, AFDC o Seccion 8? Si No

Family Yearly Income: \_\_\_\_\_ Family Size: \_\_\_\_\_  
(Salario Annual) (# de personas en su hogar)

Social History: Occupation: \_\_\_\_\_ Ed. Grade completed: \_\_\_\_\_ Native Lang: \_\_\_\_\_  
(Historia Social: En que trabaja) (Grado escolar) (Idioma)

Place of Employment: \_\_\_\_\_ Read/Write: \_\_\_\_\_ Nat. Origin: \_\_\_\_\_  
(Lugar de Trabajo) (Sabe leer y escribir) (Origen Nacional)

Diabetes History:  
\_\_\_\_\_ Illness Years

Type of Treatment: \_\_\_ P.O. Meds \_\_\_ Insulin \_\_\_ Diet only \_\_\_ Combination

Referred by: \_\_\_\_\_

(Quien lo refirio)

Health Care Provider: \_\_\_\_\_ Today's date: \_\_\_\_\_  
(Clinica Anterior) (Fecha de hoy)

Last Visit ER (date): \_\_\_\_\_ Facility: \_\_\_\_\_  
(Ultima visita al ER: fecha) (facilidad)

### FOR OFFICE USE ONLY

Eligibility: \_\_\_ Diabetes Type 2 \_\_\_ Adult

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_