UCI Gender Diversity Program

Welcome to the UCI Gender Diversity Program! The confidentiality of your information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

We look forward to participating in your care. In order to best meet your needs, please complete this questionnaire and fax it to (714) 456-8808.

General Information:

Legal Name: _____ DOB: _____

Affirmed Name: _____ Pronouns: _____

Sex Assigned at birth: ____ Legal Gender Marker: ____ Birthplace: _____

Address: _____ City: _____ State: _____Zip: _____

E-mail address: _____ May we contact you by email? Y N

Home Phone #: (___)____-_____ May we contact you at this number? Y N

Cell Phone #: (___)____-_____ May we contact you at this number? Y N

Marital Status: _____

Preferred Language: _____ Need Interpreter? Yes _____ No _____

Race: _____ Ethnicity: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Home Phone #: (___)____-_____ Cell Phone #: (___)____-_____

Preferred Language: _____ Need Interpreter? Yes _____No _____

Notify on admission? Yes _____No _____ Same Address? Yes _____No _____

Employer or Student Information:

Employer or School: _____

Status: Full Time____ Part Time____

Occupation: _____ Phone #: _____

Address: _____ City: _____ State: _____Zip: _____

Payer Information: (Only applicable if patient is under 18)

Name: _____ DOB: _____

Address: _____ City: _____ State: _____Zip: _____

Relationship to patient: _____ Same Address? Yes _____No _____

Payer Employer Information:

Employer: _____ Status: Full Time____ Part Time____

Occupation: _____ Phone #: _____

Address: _____ City: _____ State: _____Zip: _____

Insurance Information: (If Preferred, fax copy of front and back of insurance card)

Subscriber Name:_____ Insurance Plan:_____

Subscriber ID #: _____ Group #: _____ Subscriber DOB: _____

Effective Date: _____ Provider Service Phone #: _____

For Tricare:

Sponsor SSN: _____

Primary Care Physician Information:

Name: _____

Address: _____ City: _____ State: _____Zip: _____

Primary Phone #: (___)____-_____ Fax #: (___)____-_____

Preferred Pharmacy Information:

Name: _____

Address: _____ City: _____ State: _____Zip: _____

Diagnostics Laboratory: (circle one) Quest LabCorp

Thank you again for completing this confidential form!

Signature: _____

Printed Name: _____ Date: _____