Carroll County Health Department
Reproductive Health Patient Demographic Form

Name (First, Middle, Last):

Preferred Name:

Date of Birth (MM/DD/YYYY):

Gender Assigned at Birth:

Gender Identity:

Sexual Orientation:

Marital Status:

Race:

Ethnicity: Are you Hispanic/Latino? YES ☐ NO ☐

Employment (select): FULL TIME ☐ PART TIME ☐ STUDENT ☐
UNEMPLOYED ☐ RETIRED ☐

Employer:

Preferred Mailing Address:

(Street/Apartment #):

(City/State/Zip):

Home Phone: Cell Phone:

Do you consent to text message reminders and alerts (check one)? YES ☐ NO ☐

Email Address:

Emergency Contact Name:

Emergency Contact Phone:

Insurance (Name of Insurance Carrier or None):

Primary Insurance Holder Name:

Relationship to Insurance Holder:

Policy Number:

Group Number:

Effective Date:

Please take a photo of the front and back of your insurance card and email to:

cchd.reprohealth@maryland.gov. ***You will need a photo ID at the time of your appointment.***