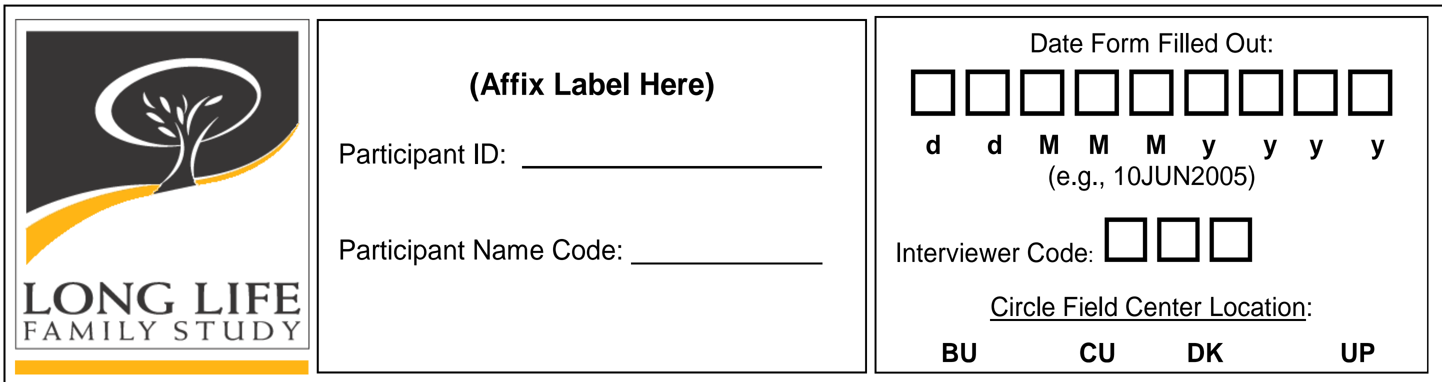

LLFS Participant Contact Information

Interviewer Note: ***This form is to be kept in a confidential file, separate from data entry forms.***

1. What is your name? ____
   PREFIX FIRST NAME MI LAST NAME

2. What is your home address? (Street, City, State, Zip) ______________________________

____

____

3a. What is your home telephone number? ______________________________

3b. What is an alternate telephone number? ______________________________

4a. **US:** What is your Social Security Number? (*Check this box if refused to provide* ☐)

SSN: ___ ___ ___ -- ___ ___ -- ___ ___ ___ ___

4b. **DK:** What is your CPR (Civil Public Registry) Number? (*Check this box if refused to provide* ☐)

CPR: ___ ___ ___ ___ ___ ___ -- ___ ___ ___ ___

5. **US:** What is your Medicare Number? (*Check this box if refused to provide* ☐)

Medicare ID: ___ ___ ___ ___ ___ -- ___ ___ ___ ___ ___ ___ ___

6a. Please provide the name of the person who you would want us to ask to provide information and answer questions for you in the event that you are unable to answer for yourself.

Name: ____
PREFIX FIRST NAME MI LAST NAME

6b. Is this person a family member enrolled in LLFS?

☐ 1 ....Yes **Go to 7a**
☐ 0 ....No

6c. Address (Street, City, State, Zip) ____

____

____

Phone: ________________________ (□ Home □Work) Best day/time to call: ___________

E-Mail Address: ______________________

6d. Relationship to You (i.e. spouse, friend, etc.): ____________________________

7a. Do you have a primary care physician or a specific location that you ***usually*** go to for health care or for advice about your health care?

- □[1] ....Yes
- □[0] ....No

***Interviewer Note*: Please read response options for 7b and check only one.**

7b. Where do you ***usually*** go for health care or advice about health care?

- □[1] ....Private Doctor's Office (individual or group practice)
- □[2] ....Public Clinic, such as a neighborhood health center
- □[3] ....Health Maintenance Organization (HMO)
- □[4] ....Hospital Outpatient Clinic
- □[5] ....Emergency Room
- □[6] ....Other (Please Specify)________________________
- □[D] ....Don't Know
- □[R] ....Refused

7c. Please tell me the name, address and telephone number of the doctor or health care provider that you usually visit for health care needs.

Organization Name: ____

Physician Name: ____
PREFIX **FIRST NAME** **MI** **LAST NAME**

Address (Street, City, State, Zip): ____

____

____

Office Phone: ______________________ Office Fax: ______________________

E-Mail Address: ______________________________