Health First Community Health Center

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	BIRTHDATE	SEX ☐ MALE ☐ FEMALE	NICKNAME

PATIENT'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	**STATE**	**ZIP**

PATIENT'S PHYSICAL ADDRESS (if different from billing/mailing address)

STREET ADDRESS		
CITY	**STATE**	**ZIP**

PATIENT'S CONTACT INFORMATION

HOME PHONE #	CELL PHONE #	E-MAIL ADDRESS

Preferred Method for Notifications (check all that apply) ☐ Phone ☐ Text ☐ E-mail ☐ Automated Recordings

PATIENT'S EMERGENCY CONTACT INFORMATION

NAME	ADDRESS	RELATIONSHIP	CONTACT PHONE NUMBER

PATIENT'S ADDITIONAL INFORMATION – For Purposes of Grant Funding

RACE

☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ ASIAN
☐ BLACK/AFRICAN AMERICAN
☐ NATIVE HAWAIIAN
☐ OTHER PACIFIC ISLANDER
☐ WHITE
☐ MORE THAN ONE RACE

ARE YOU OF HISPANIC OR LATINO ORIGIN? ☐ YES ☐ NO

AGRICULTURAL WORKER
☐ MIGRANT ☐ SEASONAL

ARE YOU A VETERAN OF THE U.S. ARMED FORCES?
☐ YES
☐ NO

PRIMARY LANGUAGE
☐ ENGLISH ☐ SPANISH
☐ OTHER _____

DO YOU NEED INTERPRETER SERVICES?
☐ YES ☐ NO

MARITAL STATUS
☐ SINGLE
☐ MARRIED
☐ DIVORCED
☐ WIDOW
☐ LEGALLY SEPARATED
☐ LIFE PARTNER
☐ OTHER _____

HOUSEHOLD SIZE
☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10
☐ OTHER ___

ESTIMATED HOUSEHOLD INCOME
$ _____
☐ WEEKLY
☐ BI-WEEKLY
☐ MONTHLY
☐ ANNUALLY

GENDER IDENTITY
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE (Female-to-Male/FTM)
☐ TRANSGENDER FEMALE (Male-to-Female/MTF)
☐ OTHER
☐ CHOOSE NOT TO DISCLOSE

SEXUAL ORIENTATION
☐ STRAIGHT or HETEROSEXUAL
☐ LESBIAN, GAY or HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ CHOOSE NOT TO DISCLOSE

HOUSING STATUS

☐ CURRENT RESIDENT OF PUBLIC HOUSING
☐ HOMELESS ___Doubling Up ___Shelter ___Transitional ___Unknown/Other _____
☐ NOT HOMELESS AND NOT CURRENT RESIDENT OF PUBLIC HOUSING

RESPONSIBLE PARTY'S INFORMATION (if different than patient)

NAME (Last, First, Middle)	PREVIOUS LAST NAME	NICKNAME

SSN	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS (if different than patient)

STREET OR PO BOX			
CITY	**STATE**	**ZIP**	**HOME PHONE NUMBER**

Health First
Community Health Center

PATIENT INTAKE

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PATIENT'S EMPLOYER

NAME OF EMPLOYER	
TYPE OF BUSINESS	OCCUPATION
EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED	

PRIMARY INSURANCE

TYPE OF PRIMARY COVERAGE ☐ MEDICAID ☐ MEDICARE ☐ PRIVATE INSURANCE ☐ NONE ☐ OTHER _____

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

PREFERRED PHARMACY

PHARMACY NAME	PHARMACY LOCATION

CONSENT FOR TREATMENT

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Health First Community Health Center, provider or suppliers for services. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures, which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy. I authorize HFCHC to contact me by phone.

Patient Signature_____**Date**_____

Responsible Party's Signature_____**Date** _____

Witness _____

RELEASE OF MEDICAL RECORDS

In the event that the provider refers me to a specialist (a provider outside of Health First), I hereby authorize Health First to release my medical records as required to the indicated specialty provider for the purpose of continuity of care.

I understand this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol) abuse information, if it exists. If there is a need for the release of behavioral health records, etc, I will be notified of the need to sign a separate release of information form.

I understand that if I am referred to a specialist, Health First will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, can't see the patient in a timely manner, or is unavailable, the Health First referral team will seek similar specialists to provide care for the patient.

I understand that this release of my medical information is required to facilitate a referral stays in force unless I revoke it in writing to Health First.

Patient Signature_____**Date**_____

Co-Signature (if needed) _____**Date**_____

ACKNOWLEDGEMENTS (PLEASE READ, CHECK THE BOXES, AND SIGN/DATE BELOW)

1. **Cancellation of Appointments. I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary.**
2. **No Call / No Show. I understand that missing 3 appointments within 12 months as a no call/no show may cause me to be discharged from the practice.**
3. **Transportation. I understand that if I have any problems getting my child to an appointment, I can let Health First know and they may be able to help me with transportation.**
4. **Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.**
5. **Patient Rights and Responsibilities. I have received a copy of my Patient Rights and Responsibilities.**
6. **Responsibility for Payment. For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Health First CHC the full amount of all charges incurred. I/we understand that Health First CHC will file commercial insurance as a courtesy. Health First will allow 30 days for the insurance to resolve the outstanding charges. After the 30 days, any remaining charges will become due and payable by the financially responsible person(s).**
7. **Co-pays, co-insurance and sliding scale fees are due at the time of service.**

Parent / Guardian Signature:_____ **Date:**_____

Co-Signature (if needed)_____ **Date:**_____

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** – Gives the health care provider information about which drugs are covered by your drug benefit plan
- **Medication history transactions** – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Health First, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form, you are agreeing that your provider at Health First may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the bases for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent for Health First to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ Print Patient Name _____ Patient DOB

_____ Signature of Patient or Guardian _____ Today's Date

_____ Relationship to Patient

Health First Community Health Center
(Regional Health Care Affiliates, Inc.)
Authorization for Release of Patient Information
Health First Internal Clinic Use Only

I hereby authorize Regional Health Care Affiliates, Inc. dba Health First Community Health Center, to release to the person(s) listed below any information regarding my care, diagnoses, appointment times, test results, procedures, behavioral health information, HIV/AIDS status, substance abuse or prognosis at any time.

NAME	TELEPHONE	RELATIONSHIP TO PATIENT

I hereby authorize the following individuals to bring my minor child/children to appointments at Regional Health Care Affiliates, Inc. dba Health First Community Health Center in my absence. I hereby grant permission for them to have full decision-making ability in my absence.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

Note: This information and direction will remain in force until the patient or responsible party revokes the document.

Health First
Community Health Center

Health History

Name_____ Date of Birth_____
(month/day/year)

I. ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks):			
#	Yes	No	**Questions**
1			Do you have a primary care physician? Who?_____ Date of last exam:_____
2			Do you have a dentist? Who?_____ Date of last exam: _____
3			Have you been hospitalized or had a serious illness/injury in the last three years? Why? _____
4			Do you have chronic pain? When?_____ Where?_____ How often or frequent? _____
5			List current prescriptions (include vitamins, herbs, & supplements): _____

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
6			Allergies to medications _____	16			Allergies to food or other _____
7			Hepatitis	17			High blood pressure
8			Anemia	18			Kidney or bladder disease
9			Arthritis	19			Psychiatric Illness _____
10			Asthma or Emphysema	20			Sexual disease: Chlamydia, Herpes, etc. _____
11			Cancer, Where? _____	21			Skin disease or rashes
12			Diabetes or Gestational (pregnant) Diabetes	22			Stomach problems: gastritis, ulcer, other _____
13			Eye disease: glaucoma, cataract, _____	23			Stroke
14			Ear, nose or throat problems	24			Thyroid, adrenal disease
15			Heart Disease				

III. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
25			Artificial joint	29			Heart valve or pacemaker
26			Blood transfusions	30			Surgeries (including sterilization) _____
27			Chemotherapy / Radiation	31			Domestic abuse
28			Contact lenses or glasses				

IV. WOMEN ONLY (Check Yes or No):

#	Yes	No	Questions	#	Yes	No	Questions
32			Are you pregnant or breast feeding?	38			When was your last pap? _____
33			Are you taking birth control pills or shots?	39			Have you had an abnormal pap?
34			Do you have difficult periods?	40			When was your last mammogram? _____
35			Have you had any miscarriages or abortions?	41			Have you had an abnormal mammogram?
36			More than 1 sexual partner recently?	42			Have you had a hysterectomy? Full or partial?
37			Do you have pain with intercourse?	43	At what age did you start your first period? _____		

V. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Check Yes or No):

#	Yes	No	Questions	#	Yes	No	Questions
44			Swollen ankles	55			Dry mouth
45			Bleeding problems / bruising easily	56			Nausea and vomiting
46			Chest pain (angina)	57			Rashes
47			Cough: persistent or bloody	58			Seizures
48			Diarrhea, constipation, blood in stools	59			Shortness of breath
49			Dizziness	60			Sinus problems
50			Fever	61			Difficulty swallowing
51			Fainting	62			Excessive thirst
52			Headache	63			Frequent or bloody urine
53			Jaundice	64			Blurred vision
54			Joint pain or stiffness	65			Recent weight gain or loss

VI. OTHER INFORMATION (Check Yes or No and fill in the blanks):

#	Yes	No	Questions
66			Do you have any other diseases or medical conditions NOT listed on this form? If so, please explain: _____
67			Please list any significant family medical history: _____
68			Are you able to perform activities of daily living (ADL)? If no, please explain: _____
69			Do you have a religious, cultural, physical, or other factors that might influence your care? If so, please list: _____

VII. DO YOU USE ANY OF THE FOLLOWING? (Check Yes or No and fill in the blanks):

#	Yes	No	Questions	#	Yes	No	Questions
70			Alcohol frequency _____	72			Tobacco (smoke or chew) _____
71			Caffeine frequency _____	73			Recreational drug frequency _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health or medications.

Patient or Guardian's Signature (If under 18)_____ **Date** _____

For office use only: Baseline evaluation (all new illnesses are documented on the ongoing problem list)

Sliding Scale Program

A **sliding scale** discount program is available for our uninsured and under-insured patients who may have difficulty paying.

□ **Yes**, I am interested in information regarding the sliding scale program.

□ **No**, I am not interested at this time in the sliding scale program.

Signature: _____

Date:_____

Once the paper is signed, please return it to the receptionist.