Patient Name _____ Date of Birth _____ Today's Date _____ 02102023

Upstate Family Health Center, Inc.

1001 Noyes Street
Utica, NY 13502
315-624-9470 phone
www.upstatefamilyhealthcenter.org

205 W. Dominick Street
Rome, NY 13440

Patient Information

Last Name	First Name (Legal)		Middle		Suffix
Mailing Address	Apt	City	State	Zip	Country
Physical Address	Apt	City	State	Zip	Country
Mobile Phone Number	Employer Name		Social Security Number		
Home Phone Number	Email Address		Date of Birth		
Emergency Contact Name	Emergency Contact Number		Relationship to Emergency Contact		
UFHC Location Preference ❑ Utica ❑ Rome	Veteran ❑ Yes ❑ No		Primary Spoken Language		Interpreter Needed? ❑ Yes ❑ No

Patient Statistics

As a Federally Qualified Health Center (FQHC), we are able to offer services to all our patients, including the underserved, as a result of our Federal designation. As a FQHC, we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

Marital Status
❑ Single ❑ Divorced
❑ Married ❑ Separated
❑ Other

Race
❑ Caucasian/White
❑ Asian
❑ Black/African American
❑ American Indian/Alaska Native
❑ Pacific Islander
❑ Native Hawaiian
❑ Choose not to disclose

Ethnicity
❑ Latino/Hispanic
❑ Not Latino/Hispanic
❑ Choose not to disclose

Sexual Orientation
❑ Straight ❑ Something Else
❑ Lesbian or Gay ❑ Don't know
❑ Bisexual ❑ Choose not to disclose

Gender Identity
❑ Male
❑ Female
❑ Transgender Male (Female to Male)
❑ Transgender Female (Male to Female)
❑ Other
❑ Choose not to disclose

Living Type (check if applies)
❑ Homeless ❑ Transitional Housing ❑ Migrant Worker ❑ Seasonal Worker

Do you need assistance with accessing community resources?
❑ Yes ❑ No

Annual Household Income
❑ <$10,000 ❑ $10-$20,999 ❑ $21-$30,999 ❑ $31-$40,999
❑$41-$50,999 ❑ $51-$60,999 ❑ over $70,000

Household Size: (Number of people in household this income supports)
Adults:_____ Children: _____ If you have children, are they students of any of these Utica Schools:? ❑ MLK ❑ Donovan ❑ Kernan

Responsible Party (if other than patient)

First Name	Middle	Last Name		
Relationship to the Patient ❑ Spouse ❑ Partner ❑ Parent ❑ Child ❑ Other _____				
Social Security Number	Date of Birth			
Mailing Address	City	State	Zip	Country
Email Address	Preferred Phone Number	Alternate Phone Number		

Primary Insurance Information

Subscriber Name (Name on Insurance Card)	Subscriber SSN	Subscriber DOB
Plan Carrier (Insurance Company)	Subscriber ID #	Group #

Patient Name	Date of Birth	Today's Date

Secondary Insurance Information

Subscriber Name (Name on Insurance Card)	Subscriber SSN	Subscriber DOB
Plan Carrier (Insurance Company)	Subscriber ID #	Group #

Additional Parent/Guardians (if applicable)

First Name	Last Name	Date of Birth
Relationship to the Patient ❑ Parent ❑ Guardian ❑ Other _____	Guardian Phone Number (_____) _____ - _____	
First Name	Last Name	Date of Birth
Relationship to the Patient ❑ Parent ❑ Guardian ❑ Other _____	Guardian Phone Number (_____) _____ - _____	

Mother's Maiden Name: _____

Pharmacy Information

Name of patient's primary pharmacy	Address/Location
Name of patient's mail order pharmacy	Address/Location

I UNDERSTAND THAT MY MEDICATION HISTORY MAY BE OBTAINED UTILIZING AN ELECTRONIC INFORMATION EXCHANGE AND THAT THIS PROTECTED HELATH INFORMATION MAY BE VALUABLE INFORMATION FOR MY HEALTH CARE PROVIDER.

I hereby authorize Upstate Family Health Center, Inc. to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Signature of Patient, Parent and Guardian	Date

Appointment Reminders/Patient Portal Access

How would you like to receive appointment reminders and care notifications via? ❑Text ❑ Voicemail ❑ Email	Would you like to access our patient portal? ❑ Yes ❑ No (If yes, please provide your email address)

INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT AND RELEASE: I hereby authorize any and all insurances on file for my account to be paid directly to the agency and acknowledge that I am financially responsible for any unpaid balance. I also authorized the Agency to release any information required by my insurance company including medical, surgical, drug, alcohol, and psychiatric information. Release of HIV/AIDS information may require further authorization. I understand that if I am pending Medicaid that I will be billed for the full amount for services until accepted by Medicaid.

CONSENT TO TREAT

I hereby give consent for treatment or therapeutic intervention, which may include evaluations, routine diagnostic procedures, and tests as the health care professionals at Upstate Family Health Center, Inc. consider necessary. I acknowledge that this consent form has been explained to me and I have had my questions answered, and the explanation that I received is sufficient for me to give consent for treatment.

_____ _____

Patient Signature/Legal Representative (Consent to treat and bill) **Date**

_____ _____

Authorized individual and relationship to patient (Consent to treat and bill) **Date**

Patient Name _____ Date of Birth _____ Today's Date _____

Past Medical History

Do you have or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Hep C

Other medical conditions (please list):

Family History

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings 1				
2				
3				
4				
5				
Children 1				
2				
3				
4				
5				

EXTENDED FAMILY HEALTH & PSYCHIATRIC PROBLEMS PAST & PRESENT:

Mother's Side:

Father's Side:

Patient Name	Date of Birth	Today's Date

Allergies

❑ Medication Allergies? Which ones?	❑ Food Allergies?
❑ Outdoor Allergies?	❑ Other Allergies?

Current Medication/Vitamins/Supplements

Name of Medication	Strength	How Many?	How Often?

Lifestyle

Do you smoke?
❑ Yes ❑ How Much? _____
❑ Previously, but quit
❑ Never smoked

Do you exercise?
❑ No
❑ Yes ❑ What kind? _____
❑ How Often? _____

Do you drink alcohol?

❑ No ❑ Yes ❑ How Much? _____

In the past year, how often did you have more than 5 drinks in a day? _____

Additional Information

Have you seen any other doctors now or in the past? If so, please list them below:

Do you have any current concerns you want to discuss with the provider?