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

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 |
|---|---|---|---|---|---|
| | | | | | |

| Phone Number | ❑ Cell ❑ Home | Email Address |
|---|---|---|
| | | |

| Social Security Number | Date of Birth | Employer Name | Occupation |
|---|---|---|---|
| | | | |

| 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 | Race | | Ethnicity |
|---|---|---|---|
| ❑ Single | ❑ Caucasian/White | ❑ Pacific Islander | ❑ Latino/Hispanic |
| ❑ Married | ❑ Asian | ❑ Native Hawaiian | ❑ Not Latino/Hispanic |
| ❑ Divorced | ❑ Black/African American | ❑ More than one | ❑ Choose not to disclose |
| ❑ Separated | ❑ American Indian/Alaska Native | ❑ Other | |
| ❑ Other | | ❑ Choose not to disclose | |

| Sexual Orientation | | Gender Identity | |
|---|---|---|---|
| ❑ Straight | ❑ Something Else | ❑ Male | ❑ Other |
| ❑ Lesbian or Gay | ❑ Don't know | ❑ Female | ❑ Choose not to disclose |
| ❑ Bisexual | ❑ Choose not to disclose | ❑ Transgender Male (Female to Male) | |
| | | ❑ Transgender Female (Male to Female) | |

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

| Annual Household Income | Household Size: (Number of people in household this income supports) _____ Adults:_____ Children: _____ |
|---|---|
| ❑ <$10,000 ❑ $10-$20,999 ❑ $21-$30,999 ❑ $31-$40,999 ❑$41-$50,999 ❑ $51-$60,999 ❑ over $70,000 | |

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

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 |
|---|---|

**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, or other treatment, 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?<br>❑ Yes ❑ How Much? _____<br>❑ Previously, but quit<br>❑ Never smoked | Do you drink alcohol?<br>❑ No ❑ Yes ❑ How Much? _____ |
| Do you exercise?<br>❑ No<br>❑ Yes ❑ What kind? _____<br>❑ How Often? _____ | In the past year, how often did you have more than 5 drinks in a day? _____ |

## Additional Information

Are you seeing any other doctors? If so, please list them.

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