Family Healthcare of Hagerstown

UDS Information

Date (Fecha): _____

Patient Name (Nombre del Paciente): _____ **Date of Birth** (Fecha de Nacimiento): _____

Family Size (Tamano de familia): _____ **Annual Income** (Ingreso annual de familia): $_____

The Family Size and Annual Income are for reporting purposes only. No personally identifiable information is ever reported.

This information helps us to receive funding to provide services to the community.

El tamaño de la familia y los ingresos anuales son con fines informativos exclusivamente. Ninguna información personalmente identificable es todo. Esta información nos ayuda a recevie recursos para proveer servicios a la comunidad.

Race (Raza)	**May choose more than one** (Puede elegir mas de una)	
American Indian or Alaskan Native	(Indio Americano/Nativo de Alaska)	
Black or African American	(Negro/Afroamericano)	
Mutiracial		
Native Hawiian	(Nativo de Hawai)	
Other Pacific Islander	(De las Islas del Pacifico)	
Asian	(Asiatico)	
White	(Blanco)	
Decline to Specify	(megarse a especifar)	

Ethnicity (Etnia)		**Check One**
Not Hispanic or Latino	(No Hispano O Latino)	
Hispanic or Latino	(Hispano O Latino)	
Declined to specify	(Se negó a especificar)	
Unknown/Not reported	(Desconocido / No informado)	

Migrant Status (condition de migrantes)		**Check One**
Not a farmworker (N/A)	(No es campesino)	
Migrant	(Migrante)	
Seasonal	(Trabaja temporadas)	

Housing (Casa)		**Check One**
Not Homeless	(Tiene hogar)	
Doubling Up	(Vive con otra familia)	
Shelter	(Vive en refugio)	
Street	(Vive en la calle/carro)	
Transitional	(Hogar de transicion/temporal)	

Do you live in public housing? (Viva usted en una vivienda publica?)

Yes	
No	

Do you need a translator/interpretor? (Necesita un traductor?)

Yes	
No	

Are you a veteran? (Es usted un veterano?)

Yes	
No	

Birth Mother's Full Name: (Nombre completo de la madre)

Last _____ First_____ Middle _____

Maiden_____

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.

Family Healthcare of Hagerstown
2018 Patient Registration Form

____ Family Practice
____ Dental Practice
____ Mobile (school)
____ Dental Practice & Mobile (school)

Last Name:	*First Name*:		*Middle*:
Maiden Name	*Any other names or aliases*:		
Date of Birth:	*Social Security Number*:	Sex:_____M _____F Sex:___ Undifferentiated	Email:
Cell Phone: ___ Preferred *Home Phone:* ___ Preferred *Work Phone*: ___ Preferred		*Preferred Language*: ____ English ____ Spanish ____ Russian ____Sign Language ____ Other _____	
Home Address:		City/State:	Zip:
Mailing Address (if different than Home):		City/State:	Zip:
Marital Status (please circle): Single Married Divorced Legally Separated Widowed Domestic Partener Life Partner Annulled Interlocultory Polygamous Unknown			
Student: _____ Full Time _____Part Time _____ Not a Student		*Smoker*: _____ Yes _____ No	

Who provides day to day care for this patient? _____ Self _____Parent _____ Other
If other, please provide name and phone number: _____

Name of Legal Guardian or Healthcare Proxy (person decided by the patient, family or courts to make healthcare decisions for the patient if the patient is unable to do so: ***We MUST have a copy for our records***

Name: Relationship: Phone:

Advance Directives

An Advance Directive is a form that you complete saying how much medical care you want to receive in the event that you are not able to respond. Do you have an Advance Directive? _____ Yes _____ No

Emergency Contact

If I cannot be reached, I authorize Family Healthcare of Hagerstown to release any information relating to my treatment, examination, and/or clinical results, to the person(s) listed below:

Name of Designee: _____ Phone #: _____
Relationship: _____ Date: _____
Name of Designee: _____ Phone #: _____
Relationship: _____ Date: _____

_____(initial) I authorize Family Healthcare of Hagerstown to leave messages on any phone number provided relating to appointment reminders and/or clinical results or information.

_____(initial) I authorize Family Healthcare of Hagerstown to speak to any pharmacy regarding medication management.

My signature below indicates that all the information provided on this form is true and correct.

_____ _____
Patient/Parent/Legal Guardian Date

Insurance Information

Is patient covered by insurance? ____ Yes ____ No	*Is patient covered by insurance*? ____ Yes ____ No	
Primary Medical Insurance:	*Primary Dental Insurance*:	
Policy #:	*Policy #*:	
Subscriber SSN:	*Subscriber SSN*:	

Do you have a provider you would like to be scheduled with? If so, please list: _____