

GENERAL PATIENT INFORMATION

Last Name		First Name		Middle Name	
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender at birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated		Who is your Medical Provider?	
Home Address:		City	State	Zip	
Mailing Address:		City	State	Zip	
Email Address:		Are you transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> Trans-Male to Female or <input type="checkbox"/> Trans-Female to Male			
Cell Phone:		What is your marital status? (Check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Annulled <input type="checkbox"/> Interlocutory <input type="checkbox"/> Polygamous <input type="checkbox"/> Unknown			
Home Phone:					
Student? <input type="checkbox"/> Full time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a student	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please select one: <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> More than One Race <input type="checkbox"/> Decline to Specify					
Please select one: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Decline to Specify <input type="checkbox"/> Unknown/Not Reported					
Preferred language:			Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		

EMERGENCY CONTACTS IF I CANNOT BE REACHED:

Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor))	
	Relationship:	Phone number
Date:	Emergency Contact/Designee: (Spouse, Friend, Legal Guardian, or Parent (if the patient is a minor))	
	Relationship:	Phone number:

I authorize Family Healthcare of Hagerstown to release any information relating to my treatment, examination, and/or clinical results to the person(s) above.

Initial Here

GUARANTOR/RESPONSIBLE PARTY:

Last Name		First Name		Middle Name	
Address:		City	State	Zip	
Phone Number:	Relationship to Patient:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)		

MEDICAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer:	Group #	

DENTAL INSURANCE INFORMATION:

Name of Insurance Company:		Policy #
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SS#:
Employer:	Group #	

Do you have a provider that you would like to be scheduled with? If so, who? _____

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

Patient/Parent/Legal Guardian

Date

Community Health Center
UDS (Uniform Data System) Information

Date: _____ Patient Name: _____ Date of Birth: _____

In order to continue offering the variety of services that we offer at Family Healthcare of Hagerstown and to continue to receive grant funding, we are required to collect information on every person that receives care. The information is reported as an overall number and is not reported on individual patients:

- 1) How many people live in your household? _____
What is the annual income of all family members in your household? _____
- 2) Have you or anyone in your household done agricultural (farm) work in the last 3 years?
Yes No
- 3) If yes, was it migrant farm work in which you traveled from town to town without establishing a permanent residence?
Yes No
- 4) If yes, was it seasonal farm work in which you travel and work seasonally and have an established residence in the same area?
Yes No
- 5) Are you homeless?
Yes No
- 6) If yes, where did you stay/sleep last night?
Doubled up Shelter
Street (including a car or other vehicle) Transitional (including hotel/motel)
Unknown
- 7) Do you live in public housing?
Yes No
- 8) Are you a veteran?
Yes No
- 9) What is your occupation or job? _____

Thank you for providing this important information. It will ensure that we are able to provide you with valuable services and programs in the future.

FHH Staff Initials: _____