FAMILY HEALTHCARE OF HAGERSTOWN

201 S. Cleveland Avenue
Hagerstown, MD 21740
301.745.3777 - www.familyhch.org

____ Family Practice
____ Mental Health Therapy
____ Dental Practice/Mobile
School Child Attends: _____

GENERAL PATIENT INFORMATION

Last Name	First Name		Middle Name
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender at birth ❑ Male ❑ Female ❑Undifferentiated	Who is your Medical Provider?
Home Address:	City	State	Zip
Mailing Address:	City	State	Zip
Email Address:		Gender Identity: ❑ Male ❑ Female ❑ Trans-Male to Female ❑ Trans-Female to Male ❑ Other ❑ Chose not to disclose ❑ Unknown	
Cell Phone:		What is your marital status? (Check one) ❑Single ❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Domestic Partner ❑Annulled ❑Interlocutory ❑Polygamous ❑Unknown	
Home Phone:			
Student? ❑Full time ❑Part Time ❑Not a student	Smoker? ❑Yes ❑No		

Please select one ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Other Asian ❑Native Hawaiian ❑Other Pacific Islander ❑Guamanian or Chamorro ❑Samoan ❑Black/African American ❑American Indian/Alaskan Native ❑White ❑More than One Race ❑ Unreported/Chose not to disclose race

Please select one: ❑Not Hispanic/Latino ❑Another Hispanic/Latino ❑Mexican ❑Mexican American ❑Chicano ❑Puerto Rican ❑Decline to Specify ❑Unknown/Not Reported

Please select one ❑Lesbian or Gay ❑Heterosexual (or straight) ❑Bisexual ❑Other ❑Don't know ❑Chose not to disclose ❑Unknown

Preferred language:	Do you need an interpreter? ❑Yes ❑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:

GUARANTOR/RESPONSIBLE PARTY:

Last Name	First Name		Middle Name
Address:	City	State	Zip
Phone Number:	Relationship to Patient:	Gender: ❑ Male ❑ 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? _____

- I authorize Family Healthcare of Hagerstown to release any information relating to my treatment, examination, and/or clinical results to the Emergency Contact(s) above.
- I authorize Family Healthcare of Hagerstown to leave messages on any phone number provided relating to appointment reminders and/or clinical results or information.
- My signature below indicates that all the information provided on this form is true and correct.

_____ _____

Patient/Parent/Legal Guardian Date

COMPLETE BACK OF FORM

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 ❑Permanent Supportive Housing ❑Other

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: _____