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	**Preferred Language:**
Home Address:	**City**	**State**	**Zip**
Mailing Address:	**City**	**State**	**Zip**
Email Address:		**Preferred Pharmacy:**	
Cell Phone:		What is your marital status? (Check one) ❑Single ❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Domestic Partner ❑Annulled ❑Interlocutory ❑Polygamous ❑Unknown	
Home Phone:			
Consent to Receive Automated: Calls ❑Yes ❑No **Texts** ❑Yes ❑No			

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

Ethnicity: ❑Not Hispanic/Latino ❑Another Hispanic/Latino ❑Chicano ❑Cuban ❑Mexican ❑Mexican American ❑Puerto Rican ❑Unknown/Chose not to disclose

How did you hear about us: ❑Advertising ❑Hospital ❑Insurance Company ❑Patient in the practice ❑Primary Care Provider ❑Word of mouth ❑Other

EMERGENCY CONTACT IF I CANNOT BE REACHED:

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

Advanced Directives:
An Advanced Directive is a form that you complete saying how much medical care you want to receive in the event that you are unable to respond.

Do you have an Advanced Directive? ☐ Yes ☐ No

Who provides day-to-day care for the patient? ☐ Self/The Patient ☐ Parent ☐ Other

If other, please provide a name and phone number:____

Legal Guardian/Healthcare Proxy:
Does the patient have a Legal Guardian or Healthcare Proxy (a person decided by the patient, family, or courts to make healthcare decisions for the patient if the patient is unable to do so)?

☐ No ☐ Yes (If yes, we must have a copy for our records.)

Name: ______________________________ Relationship:____________________ Phone: __________________

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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.

This information is reported as an overall number and is not reported on individual patients.

1) How many people live in your household? __________

2) What is the **annual** income of all family members in your household? $_____________

3) Have you or anyone in your household done agricultural (farm) work in the last 24 months?
❑Yes ❑No

If yes, was it **migrant** farm work? (Establish temporary home for employment) ❑Yes ❑No
If yes, was if **seasonal** farm work? (Do not establish a temporary home for employment) ❑Yes ❑No

4) Are you homeless? ❑Yes ❑No

If yes, where did you stay/sleep last night?
❑Doubled up ❑Homeless Shelter ❑Permanent Supportive Housing
❑Street (including a car or other vehicle) ❑Transitional (including hotel/motel)
❑Other ❑Unknown

5) Do you live in public housing? ❑Yes ❑No

6) Are you a veteran? ❑Yes ❑No

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 collecting paper: _________ FHH staff updating in system: _________