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)	
Home Phone:		❑Single ❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Domestic Partner ❑Annulled ❑Interlocutory ❑Polygamous ❑Unknown	
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: _____

HEALTH HISTORY

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Date of last dental visit: _____

Former dentist: _____ Reason for visit: _____

DENTAL HISTORY:

Have you ever had any of the following:

Bad breath	Yes	No
Bleeding/ Swollen/ Tender gums	Yes	No
Cigarette, pipe, cigar/ E-cig smoking	Yes	No
Clicking or popping jaw/ Jaw pain	Yes	No
Dry mouth	Yes	No

Grinding/ Clenching teeth	Yes	No
Loose teeth or broken fillings	Yes	No
Sensitivity to cold/hot/sweets	Yes	No
Sensitivity when biting	Yes	No
Other:		

How often do you floss? Once a day Twice a day Several times a day Never Other

How often do you brush? Once a day Twice a day Several times a day Never Other

MEDICAL HISTORY:

Physicians Name: _____ Date of last visit: _____

AIDS/HIV	Yes	No
Anemia	Yes	No
Arthritis/Rheumatism	Yes	No
Artificial heart valves	Yes	No
Artificial joints	Yes	No
Asthma	Yes	No
Back problems	Yes	No
Bleeding disorders	Yes	No
Cancer	Yes	No
Chemical dependency	Yes	No
Chemotherapy	Yes	No
Circulatory problems	Yes	No
Congenital heart lesions	Yes	No
Cortisone treatments	Yes	No
Cough, persistent or bloody	Yes	No
Diabetes (type)	Yes	No
Emphysema	Yes	No
Do you wear contact lenses?	Yes	No
Epilepsy/seizures	Yes	No
Fainting/dizziness	Yes	No
Frequent colds or ear infections	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Heart conditions/murmur	Yes	No
Hepatitis (type)	Yes	No
Herpes	Yes	No
High blood pressure	Yes	No
Immunological problems	Yes	No

Kidney disease	Yes	No
Learning disorders/behavior issues	Yes	No
Liver disease/Cirrhosis/Jaundice	Yes	No
Low blood pressure	Yes	No
Measles/mumps/chicken pox	Yes	No
Nervous problem	Yes	No
Pacemaker	Yes	No
Physical abuse	Yes	No
Pneumonia	Yes	No
Psychiatric care	Yes	No
Radiation treatment	Yes	No
Respiratory disease	Yes	No
Sexually transmitted disease	Yes	No
Shortness of breath	Yes	No
Sinus trouble	Yes	No
Skin rash	Yes	No
Special diet	Yes	No
Stroke	Yes	No
Swollen feet or ankles	Yes	No
Stomach problems/frequent vomiting	Yes	No
Thyroid problems	Yes	No
Tonsillitis/frequent strep throat	Yes	No
Transfusions	Yes	No
Tuberculosis	Yes	No
Tumor or growth on head or neck	Yes	No
Ulcer	Yes	No
Weight loss	Yes	No
Other _____		

MEDICATIONS:

Please list any medications you are currently taking and the reason you are taking it:

Have you used a bisphosphonate medication? (Fosamax, Boniva, etc.) Yes No

ALLERGIES:

Aspirin		Yes		No	Local Anesthetic	Yes	No
Sleeping pills		Yes		No	Penicillin	Yes	No
Codeine		Yes		No	Sulfa	Yes	No
Iodine		Yes		No	Other: _____	Yes	No
Latex		Yes		No			

HEALTH INFORMATION FOR FEMALE PATIENTS:

due date if pregnant: _____

Are you pregnant?		Yes		No
Are you nursing?		Yes		No
Are you taking birth control pills?		Yes		No

ADDITIONAL INFORMATION FOR PATIENTS AGED 10 YEARS OR YOUNGER:

Has your child been to a dentist before?		Yes		No
Has your child suffered trauma to teeth, mouth or face?		Yes, date:		No
Do you have fluoridated water?		Yes		No
Was your child premature?		Yes		No
Was your child born with any birth defects?		Yes		No
Does your child attend special classes or schools?		Yes		No
Has your child ever been hospitalized? If yes to any of the above, please explain:		Yes		No

_____ _____

Signature of Patient/ Parent or Guardian (if patient is a minor) Date

_____ _____

Printed Name of Patient/ Parent or Guardian (if patient is a minor) Date

Consent Form

Patient name: _____ **DOB:** _____

Consent to Treat:
I consent to the treatment and procedures that may be performed during my appointment. I have the right to make informed decisions about my healthcare, including the refusal of a treatment or procedure. I understand healthcare students may participate in my care.

Consent to Share Medical Record/Personal Health Information:
I understand that my medical record and/or related personal health information may be shared with the different departments of Family Healthcare of Hagerstown and also with offices that support my care. This information will be shared only to help in my health care assessment and management. Examples of this might be information related to/from pharmacies, laboratories, and referral specialists.
I understand that at any time during the course of my medical treatment, if a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.
We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. You may "opt out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or by completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org.

Confidentiality:
I understand that Family Healthcare of Hagerstown adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given information regarding the Notices of Privacy Practices.

Medical Insurance Authorization and Assignment:
I understand all charges are due at the time professional services are rendered. I authorize Family Healthcare of Hagerstown and all its included entities, to furnish information to my insurance carriers concerning my illness and treatments. For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Walnut Street Community Health Center, Inc., DBA Family Healthcare of Hagerstown. I understand I am responsible for any amount not covered by insurance, to include co-pays and fees. I understand that Financial Assistance is available to qualifying patients.

Acknowledgement of Patient Guidelines, Rights, and Responsibilities:
I acknowledge that I have received the Patient Information Guidelines and Patients' Rights and Responsibilities and agree to abide by the policies of Family Healthcare of Hagerstown.

I understand that this consent and information, in its entirety, will remain in effect as long as I continue to receive healthcare services at Family Healthcare of Hagerstown.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Printed Name of Patient/Parent/Legal Guardian