

Family Healthcare of Hagerstown

201 S. Cleveland Ave
Hagerstown, MD 21740
o: 301-745-3777
f: 833-450-3533



An Advanced Directive is a form that states 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 routine care for the patient? Self (patient) Parent Other: Name and Phone Number: _____

Legal Guardian/Healthcare Proxy:

A Legal Guardian or Healthcare Proxy is a person decided by the patient, family or court to make healthcare decisions for the patient if the patient is unable to do so.

Does the patient have a Legal Guardian or Healthcare Proxy?

No Yes Name: _____ Relationship to Patient: _____ Phone Number: _____

If you have a provider you would like to be scheduled with, please write their name here: _____

- I authorize Family Healthcare of Hagerstown to contact the Emergency Contact listed in this form in the event that I am unresponsive or cannot be reached and the information needing to be shared with me is imperative and/or time sensitive. I understand that listing this person above does not authorize FHH to disclose any information regarding my appointments, treatments, etc. and that I must complete a separate Release of Information form to appoint individuals authorized to receive this information.
- I understand that a separate Release of Information on which the specific facility is named is required for any medical records release or acquisition.
- I authorize Family Healthcare of Hagerstown to leave messages relating to appointment reminders and/or clinical results or information on any phone numbers provided belonging to the patient or legal guardian (excludes Emergency Contacts phone number).
- My signature below indicates that all the information provided on this form is true and correct.

Signature of Patient/Parent/Legal Guardian/Healthcare Proxy

Date

In order to continue offering a variety of services and receive grant funding at FHH, we are required to collect the following information on every person that receives care at our facility.

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

How many people live in your household? _____

What is the annual income of all family members in your household? \$ _____

Have you or anyone in your household done agricultural (farm) work in the last 24 months? _____

If yes, was it migrant farm work (establish temporary home for employment)? _____

If yes, was it seasonal farm work (do not establish a temporary home for employment)? _____

Are you homeless? _____

If yes, where did you stay/sleep last night? _____

Do you live in public housing? _____

Are you a veteran? _____

FHH Consent Form

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.

Revised: 3/2026

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

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.

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.

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. I understand that calls with Family Healthcare of Hagerstown may be recorded, excluding any calls with a provider or management staff.

Medical Insurance Authorization and Assignment:

I understand all charges are due at the time professional services are rendered. 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. 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.

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.

I understand that this consent and information, in its entirety, will remain in effect for one year.

Printed Name of Signee

Patient/Parent/Legal Guardian Signature

Date

Dental Health History

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

Today's Date: _____ Reason for Visit: _____

Former Dentist: _____ Date of Last Dental Visit: _____

Dental History

Have you ever had any of the following (check all that apply):

<input type="checkbox"/> Bad breath
<input type="checkbox"/> Bleeding, swollen or tender gums
<input type="checkbox"/> Smoking (pipe, cigarette, cigar, etc.)
<input type="checkbox"/> Clicking or popping jaw or jaw pain
<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Grinding/clenching teeth
<input type="checkbox"/> Loose teeth or broken fillings
<input type="checkbox"/> Sensitivity to hot/cold or sweets
<input type="checkbox"/> Sensitivity when biting

How often per day do you floss?	<input type="checkbox"/> Once	<input type="checkbox"/> Twice	<input type="checkbox"/> Several	<input type="checkbox"/> Never	<input type="checkbox"/> Other
How often per day do you brush?	<input type="checkbox"/> Once	<input type="checkbox"/> Twice	<input type="checkbox"/> Several	<input type="checkbox"/> Never	<input type="checkbox"/> Other

Health History

Physician's Name: _____ Date of Last Visit: _____

Have you ever had any of the following (check all that apply):

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis/Rheumatism	<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Asthma	<input type="checkbox"/> Back problems	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chemical dependency
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Circulatory issues	<input type="checkbox"/> Congenital heart lesions	<input type="checkbox"/> Cortisone treatments	<input type="checkbox"/> Cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Do you wear contacts?	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Fainting/dizziness
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart conditions
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Immunologic issues	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Learning disorder	<input type="checkbox"/> Behavioral issues	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Measles or chicken pox	<input type="checkbox"/> Nervous problems	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> STD	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Sinus issues	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Special diet	<input type="checkbox"/> Stroke	<input type="checkbox"/> Swollen feet/ankles
<input type="checkbox"/> Stomach issues	<input type="checkbox"/> Frequent vomiting	<input type="checkbox"/> Thyroid issues	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Frequent strep throat
<input type="checkbox"/> Transfusions	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tumor on head/neck	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Other: _____				

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**Medications**

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

Medication Name	Reason Taking

Have you used bisphosphonate medications (Fosamax, Actonel, Ateiva, Didronel, Boniva, etc.)? Yes No

Allergies Please mark if you have an allergy to any of the following:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Latex
<input type="checkbox"/> Sleeping pills	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Other:	

For patients 10 years of age and younger:

Is this the child's first visit to the dentist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child had trauma to the teeth, mouth or face?	<input type="checkbox"/> Yes; date: _____	<input type="checkbox"/> No
Do you have fluorinated water?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your child premature?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your child born with any birth defects?	<input type="checkbox"/> Yes; _____	<input type="checkbox"/> No
Does your child attend special classes at school?	<input type="checkbox"/> Yes; _____	<input type="checkbox"/> No
Has your child ever been hospitalized?	<input type="checkbox"/> Yes; _____	<input type="checkbox"/> No

For female patients only:

Are you pregnant?	<input type="checkbox"/> Yes; due date: _____	<input type="checkbox"/> No
Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking birth control pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

 Printed Name of Signee

 Signature of Patient/Parent/Legal Guardian

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