Patient Intake Form

Please have insurance card and photo ID ready

General Information – Please answer **all** questions below:

First Name: _____ **MI:** _____ **Last Name:** _____

First Name Used: _____ **Previous Last Name(s):** _____

Birthdate: _____ / _____ / _____ **Social Security #:** _____- _____ - _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

(Y/N) **Home Phone:** _____ (Y/N) **Cell Phone:** _____ (Y/N) **Work Phone:** _____

May we leave a message? Yes No **If yes, on your:** Home Phone Cell Phone Work Phone

How would you like to be notified about your appointments? Call Text Both

Current Primary Care Provider/Location: _____

Emergency Contact Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Occupation** _____ Full-Time Part-time Unemployed Retired

Are you a One Health employee or dependent of a One Health employee? Yes No

If yes, name of Employee: _____

Online Patient Portal Authorization

We encourage the use of our Online Patient Portal where you can access your chart to see your information such as lab and x-ray results, current medication list & communicate with your provider via a secure email. Often, this secure email is the fastest way to communicate with your provider.

Do you wish to sign up? Yes No

Email: _____

Preferred Language: _____ **Translator Needed:** Yes No

Sex per birth certificate: Female Male **Marital Status:** Married Single Widowed Divorced Separated

What Country are you from: United States Other_____ Choose not to answer

Race/Ethnicity	Sexual Orientation	Gender Identity
Hispanic or Latino Non-Hispanic **(Circle ALL that apply)** American Indian/Alaskan Native White/Caucasian Black/African American Native Hawaiian Asian Other Pacific Islander Other: _____	Straight (heterosexual) Lesbian/Gay (homosexual) Bisexual Something Else Don't Know Choose not to answer	Male/Man Female/Woman Transgender Man/Male Transgender Woman/Female Other _____ Choose not to answer

Individual Responsible for Bill: _____

Relationship to Patient: _____ **DOB:** _____

Billing Address: _____ **City**: _____**State**: _____ **Zip**: _____

Home Phone: _____**Cell Phone**: _____**Work Phone:** _____

Agricultural worker: Yes No Decline **Are you a student?** Yes No If yes, Full-time / Part-time

Homeless status: Yes No Decline

Veteran status: If you served in the active military, naval, or air service, which includes full-time service in the Air Force, Army, Coast Guard, Marines, Navy, or as a commissioned officer of the Public Health Service or National Oceanic and Atmospheric Administration or served in the National Guard or Reserves on active-duty status, **choose:** Yes No Decline

Preferred Pharmacy/Location: _____

Please circle the RANGE which corresponds to your household size *(how many people live in your home)* **and income** *(your total income before tax):*

Household Size	Household Income									
	from	*to*	*from*	*to*	*from*	*to*	*from*	*to*	*from*	*to*
1	none	$ 13,590	$ 13591	$ 20385	$ 20,386	$ 23,783	$ 23,784	$ 27,180	$ 27,181	and above
2	none	$ 18,310	$ 18,311	$ 27,465	$ 27,466	$ 32,043	$ 32,044	$ 36,620	$ 36,621	and above
3	none	$ 23,030	$ 23,031	$ 34,545	$ 34,546	$ 40,303	$ 40,304	$ 46,060	$ 46,061	and above
4	none	$ 27,750	$ 27,751	$ 41,625	$ 41,626	$ 48,563	$ 48,564	$ 55,500	$ 55,501	and above
5	none	$ 32,470	$ 32,471	$ 48,705	$ 48,706	$ 56,823	$ 56,824	$ 64,940	$ 64,941	and above
6	none	$ 37,190	$ 37,191	$ 55,785	$ 55,786	$ 65,083	$ 65,084	$ 74,380	$ 74,381	and above
7	none	$ 41,910	$ 41,911	$ 62,865	$ 62,866	$ 73,343	$ 73,344	$ 83,820	$ 83,821	and above
8	none	$ 46,630	$ 46,631	$ 69,945	$ 66,946	$ 81,603	$ 81,604	$ 93,260	$ 93,261	and above

If more than 8 people, what is the patient's family size? _____ and income $

DO YOU WISH TO APPLY FOR THE SLIDING FEE DISCOUNT? YES NO *If yes, please fill out SFDP application*

Do you currently have Medical Insurance? Yes No

Primary Insurance:	**Secondary Insurance:**
ID/Subscriber #:	**ID/Subscriber #:**
Group #:	**Group #:**
Policy Holder:	**Policy Holder:**
Policy Holder DOB:	**Policy Holder DOB:**
Policy Holder SSN:	**Policy Holder SSN:**
Policy Holder Phone #:	**Policy Holder Phone #:**

Do You Currently have Dental Insurance? Yes No If yes, please provide information below:

Dental Insurance Provider: _____ **ID #** _____

Acknowledgement of Consumer Bill of Rights: I acknowledge receipt of the Consumer Bill of Rights. _____ **(Initial)**

Acknowledgement of Privacy Practices: I acknowledge receipt of the Notice of Privacy Practices. _____ **(Initial)**

Acknowledgement of Payment Policy: I understand the Payment Policy and agree to abide by it. _____ **(Initial)**

Authorization for Verbal Release of Personal Health Information

Would you like to designate a family member or other individual with whom the provider may discuss your medical condition?
No Yes If yes, whom?

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this authorization in writing at any time.

Patient Name (Print)	Signature (Patient/Personal Representative)
Date	Relationship to Patient

Staff Signature: _____ Date: _____

Consent & Assignment

I consent to integrated medical, mental health, behavioral health and dental services for me or the individual for whom I am the personal representative and hereby accept responsibility to pay for such services. I know that it is my choice to have services and can change my mind about receiving services at One Health.

In the event I receive family planning services, I understand that such family planning services are provided on a voluntary basis and are not a pre-requisite to eligibility for, or receipt of, any other services or programs of One Health. Individuals 18 years of age and younger may consent to the receipt of family planning services without parental notification or consent. All information as to personal facts and circumstances obtained by One Health staff will be held strictly confidential and will not be disclosed without your written consent, except as necessary to provide services to you or as required by law, with appropriate safeguards for confidentiality.

I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my healthcare visits.

I hereby designate One Health as my lawful agent and assign to One Health any benefits for medical, dental, behavioral health, mental health, or any other services I receive from One Health which I may be entitled to. You may ask for a copy of this form or any form that you sign.

Patient Name (Print)	Signature (Patient/Personal Representative)
Date	Relationship to Patient

I further consent to receiving the services described above via telehealth if it is necessary or appropriate for the current situation. Telehealth uses electronic communications, such as real time audio, video, and data communications, so health care providers at different locations can share a patient's health information to diagnose, consult, and/or treat the patient. To protect the privacy and security of patient health information, all electronic communications used for telehealth comply with network and software security protocols. As with any health care service, there are benefits and possible risks with the use of telehealth. The benefits of using telehealth include improved access to health care and the expertise of providers and/or specialists who are not physically located in the geographic area. Possible risks of using telehealth include possible delay in diagnosis or treatment due to technical difficulties with equipment; information being sent is not sufficient to allow for a complete medical exam by the offsite provider; information may be lost when being sent due to technical failures; and despite security protocols being in place, the privacy of patient health information may be compromised when sent electronically. If I participate in a telehealth session where I am located outside of the clinic, I understand that there is potential for other people to overhear sessions if I am not in a private place. In such cases, I understand that it is my obligation to take reasonable steps to ensure my privacy. I have the right to withhold or withdraw my consent to the use of telehealth without affecting my right to future care or treatment. By signing in the space below, I consent to receive services via telehealth.

Patient Name (Print)	Signature (Patient/Personal Representative)
Date	Relationship to Patient

Thank you for taking the time to provide this most useful information!