

# Families First

support for families...health care for all

## PATIENT INTAKE FORM - PLEASE PRINT CLEARLY

Please PRINT patient's name clearly: \_\_\_\_\_

How did you hear about Families First? Please circle the one that most applies:

FF Family Center Staff    FF Health Center Staff    Flyer/Brochure/Poster    Friend/Relative    Hospital    Internet  
Insurance Directory/Phone Book    Medical/Other Professional    Newspaper/Radio/TV    Other    School  
Social Service Agency    Please provide details (e.g. paper, other, etc.) \_\_\_\_\_

### Does the patient have health insurance?

- No, and patient is an adult. (Please ask for an application to see if you are eligible for the **Sliding Fee Scale Discount.**)
- No, and patient is a child. (Parent/Guardian: Please ask for NH Healthy Kids assistance.)
- Yes. (Please fill in the information in the box below.)

PLEASE PROVIDE ANY CARD(S) SO WE MAY MAKE A COPY. THANK YOU.

SeaCare #: \_\_\_\_\_

Medicare #: \_\_\_\_\_

If you have Medicare coverage, a payment authorization must be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked. Please complete and sign the gray box located at the bottom of the signature page.

Medicaid/Healthy Kids #: \_\_\_\_\_

### Primary Health Insurance (Please complete ALL lines below)

Insurance Co. \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Certificate #: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_  
Group #: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
Effective Dates: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

### Secondary Health Insurance

Insurance Co. \_\_\_\_\_ Certificate #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

If you have insurance, who is listed as your primary care physician (PCP)? \_\_\_\_\_

Contact your insurance company to ensure that your services will be covered. Some insurance companies will pay only if you go to an "in network" provider. While Families First will bill all insurance companies, we are not in network with all. You will be responsible for any bills not covered by insurance.

Please complete both sides

# PATIENT INTAKE FORM - PLEASE PRINT CLEARLY

Full **Legal** Name: \_\_\_\_\_ Maiden or Other Name / Alias: \_\_\_\_\_  
First Middle Initial Last

Street: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Social Security # : \_\_\_\_\_

**Marital Status:**  Single  Married  Other **Gender:**  Female  Male

**If the patient is a child, please fill in the names below:**

Mother's Name: \_\_\_\_\_  Father's Name: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_  
(\*\*\* Must show legal documentation)

Please list any person, along with their phone number, that we can discuss your medical issues with this year:

\_\_\_\_\_ Please initial: \_\_\_\_\_

## AUTHORIZATION AND CONSENT FOR TREATMENT OF A CHILD (If the patient is a child, you must complete below.)

I, \_\_\_\_\_, born on \_\_\_\_/\_\_\_\_/\_\_\_\_, hereby give permission for Families First Health  
Parent/Legal Guardian (please print)

Center staff to examine: \_\_\_\_\_, born on \_\_\_\_/\_\_\_\_/\_\_\_\_, and conduct tests and procedures  
Child's Name  
as needed for diagnosis and care, and to give such treatment as the health center's providers deem necessary.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Child

I give permission for Families First to share my child's immunization information with his/her school. Please initial: \_\_\_\_\_

Some of the organizations that give us funding for our programs require us to report on the average income levels and the race/ethnicity of the people we serve. **Your income and race/ethnicity information will not be shared in connection with your name—it will only be shared in the form of summaries about the people we serve.** Thank you.

**RACE**  White/Caucasian

Black/African American

Asian

Hawaiian

Other Pacific Islander

American Indian/Alaskan Native

**ARE YOU HISPANIC?**  NO  YES

**ARE YOU A VETERAN?**  NO  YES

Is your primary language English?  YES  NO it is: \_\_\_\_\_ Do you need an interpreter?  NO  YES

Are you deaf?  NO  YES Do you need a sign language interpreter?  NO  YES

Are you a  Migrant or  Seasonal farm worker?

**Total # of household members, including patient:** \_\_\_\_\_

**Estimate of total household income:** \$ \_\_\_\_\_ per  Week  Month  Year

**Living arrangements:**  Rent  Own  Stay with relatives/friend  Shelter  Other temporary housing: \_\_\_\_\_

I have read and understand the following documents: Notice of Information Practices, No Show/Late Policy, Agency/Patient Contract and Consent to Use and Disclose Health Information. They are all located in Part III of the New Patient Handbook and are also available as handouts. I acknowledge that I have read and understand these documents.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please PRINT the patient's name clearly: \_\_\_\_\_

**PLEASE READ CAREFULLY!**

**SIGNATURES ARE REQUIRED BELOW BEFORE YOU MAY BECOME A PATIENT.**

**WE WILL ASK FOR YOUR SIGNATURE EVERY TWELVE MONTHS.**

**The Foundation for Seacoast Health  
Community Campus  
Safe Campus Restrictions**

In order to keep children and others on the community campus safe, our landlord, (The Foundation for Seacoast Health) will not allow on the Campus people who fall into the following categories.

- People who have been determined to be a sexual offender as defined by RSA 651-B,
- People who have been determined to be an offender against children as defined by RSA 651-B,
- Individuals who may pose a risk to the safety of others.

The Foundation for Seacoast Health is requiring that Families First take steps to make sure that people who fall into the above three categories are not coming to the Community Campus.

By signing this form, I agree to the following:

- If Families First determines in its own judgment that I fall into any of the three categories listed above,
  - I will be immediately discharged from Families First, and will not receive any more services;
  - I will immediately leave the Community Campus and will not return;
  - Families First will immediately release my name and address to the Foundation for Seacoast Health; and
  - I will hold neither Families First nor the Foundations for Seacoast Health responsible for the release of my name and address to the Foundation for Seacoast Health.

The Foundation for Seacoast Health may prohibit me from coming to the Community Campus if it is determined that I fall into any of the three categories listed above.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

I hereby give permission for Families First Health Center to examine and conduct such referrals, tests and procedures as are needed for my diagnosis and care, and to give such treatment as the health center's providers deem necessary. I understand that Families First, medical and support staff, may disclose and use this information for treatment, including sharing this information with other providers to provide continuity of care.

I hereby authorize release of PHI (Personal Health Information) necessary to file a claim and audit with my insurance company and assign benefits to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier, including, but not limited to, deductible and co-payments. At the end of sixty days, billing is my responsibility. A copy of this signature is valid as the original. The information I have provided is accurate and complete to the best of my ability.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**If you have MEDICARE coverage you must sign below.**

I request that payment of authorized Medicare benefits be made to Families First of the Greater Seacoast for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked.)

Print Name of Beneficiary: \_\_\_\_\_

Medicare # \_\_\_\_\_

Signature of Beneficiary or Representative: \_\_\_\_\_

Date: \_\_\_\_\_