

# 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

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  
 Hawaiian

Black/African American  
 Other Pacific Islander

Asian  
 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

Patient Name: \_\_\_\_\_

**Pregnancy Information:**

What was the first day of your last menstrual period: \_\_\_\_\_

Have you had a pregnancy test?  YES  NO

Was it a:  Urine test  Blood test

Have you seen a doctor about this pregnancy?  YES  NO

If yes, what doctor have you seen? \_\_\_\_\_

Have you filled out a records release so we may get those records?  YES  NO

**Pregnancy History:** My last pregnancy was (year) \_\_\_\_\_

# of pregnancies \_\_\_\_\_ # of early miscarriages \_\_\_\_\_ # of early abortions \_\_\_\_\_

# of live births \_\_\_\_\_ # of late miscarriages \_\_\_\_\_ # of late abortions \_\_\_\_\_

# of living children \_\_\_\_\_ # of cesarean sections \_\_\_\_\_ # of premature births \_\_\_\_\_

Did you have any complications with any pregnancies, deliveries?  YES  NO

If yes, please explain: \_\_\_\_\_

Do you or any of your children have a birth injury or a genetic problem? \_\_\_\_\_

**Paternal Information:**

Baby's Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Other

Employed:  Full-time  Part-time

Unemployed:  Student  Retired  Disabled  Other: \_\_\_\_\_

Length of your relationship: \_\_\_\_\_ What is the highest grade in school completed: \_\_\_\_\_

RACE  White  American Indian/Alaskan Native  Hawaiian/Other Pacific Islander   
Black  White & Black  Black & American Indian/Alaskan Native   
 Asian  White & Asian  White & American Indian/Alaskan Native

Is he Hispanic?  NO  YES

Is the baby's father supportive or involved in this pregnancy?  YES  NO  Undecided

Does he:  Smoke  Use Alcohol  Abuse Alcohol  Use drugs

Is he violent or abusive?  Yes  No

Is there any history of birth defects or genetic problems in his family? \_\_\_\_\_

**Please list everyone in your household:**

Name (First, Middle, Last)	Date of Birth (mm/dd/yy)	This person's relationship to you?	Weekly income	Will this person be using our programs?	Gender (M or F)	Highest grade completed (Adults only)

How would you describe your life at this point? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# Families First

*support for families...health care for all*

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

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

Social Service Agency   Hospital   Friend   Relative   School   Another doctor   Welfare   FF Employee  
Phone Book   Insurance Directory   Newspaper   TV   Radio   Mailing   Flyer/Brochure   Website   Other

Please provide details (e.g. which 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 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

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## Release of Information

\_\_\_\_\_ I give my permission for the Prenatal staff to discuss my prenatal,  
initial here social, and nutritional needs with Harbour Womens' Health Center and the  
Portsmouth Regional Hospital Family Centered Maternity Unit. I may  
revoke this permission by calling any member of the Prenatal clinic staff  
and requesting that no further information be shared. This agreement  
expires eight weeks after I deliver my baby.

Information to be disclosed:

\_\_\_\_\_ Alcohol history and treatment  
initial here

\_\_\_\_\_ Drug history and treatment  
initial here

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any **event this consent expires automatically eight weeks after I deliver my baby** or as follows:

\_\_\_\_\_  
(Specify the date, event, or condition upon which this consent expires)

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

Witness: \_\_\_\_\_ 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: \_\_\_\_\_

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\_\_\_\_\_  
(Specify the date, event, or condition upon which this consent expires)

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

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

# PHQ-9 — Nine Symptom Checklist

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

a. Little interest or pleasure in doing things

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

b. Feeling down, depressed, or hopeless

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

c. Trouble falling asleep, staying asleep, or sleeping too much

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

d. Feeling tired or having little energy

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

e. Poor appetite or overeating

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

g. Trouble concentrating on things such as reading the newspaper or watching television

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

i. Thinking that you would be better off dead or that you want to hurt yourself in some way

**Not at all**      **Several days**      **More than half the days**      **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

**Not Difficult at All**      **Somewhat Difficult**      **Very Difficult**      **Extremely Difficult**

# Prenatal Oral Health Form



Name \_\_\_\_\_ Age \_\_\_\_\_  
Provider name \_\_\_\_\_ Chart # \_\_\_\_\_ Date \_\_\_\_\_

Instructions: The Pre-Screening Section of this form can be completed by any clinic staff by asking the patients if they have experienced the conditions listed in the column. If any boxes are checked "yes" during the Pre-Screening, a Screening is required. If the Screening reveals any of the symptoms listed in the Screening Section, the patient should be referred to a dentist. Review Patient Oral Care Education Section. Then, Follow Up Section.

**1. Pre-Screening for Periodontal Disease Risk Section:** Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

Yes No

- Bleeding in the mouth or gums
- Current or past tobacco use
- Difficulty chewing foods
- Loose teeth
- Last dental visit was over a year ago

If yes to any of the above, continue to 2: Date: \_\_\_\_\_  
**2. Screening for Symptoms Section:** Initials: \_\_\_\_\_

Yes No

- Red or swollen gums
- Bleeding in the mouth or gums
- Gum recession
- Signs of pus or debris between / around the teeth.

Continue to 3 with ALL patients: Date: \_\_\_\_\_  
**3. Patient Oral Care Education Section:** Initials: \_\_\_\_\_

Yes No

- Patient referred to a dental provider (refer if "yes" to any symptoms in section 2)
- Reviewed importance of good oral care (education handout provided)
  - Brush at least two minutes two times per day
  - Floss daily
  - Visit your dental provider regularly

**Follow Up** Date: \_\_\_\_\_  
Initials: \_\_\_\_\_

Yes No

- Patient received dental care during pregnancy

Referral to: \_\_\_\_\_ Date: \_\_\_\_\_



9. Do you, or your baby's father, or any blood relative have:
- a. ...cystic fibrosis (CF)?  No  Yes  Not Sure  
*Ask your health care provider about CF screening, even if there is NO history of CF in your or your baby's father's family.*
  - b. ... fragile X syndrome?  No  Yes  Not Sure
  - c. ... muscular dystrophy?  No  Yes  Not Sure
  - d.... hemophilia or other bleeding disorder?  No  Yes  Not Sure
  - e. ... Huntington disease?  No  Yes  Not Sure
10. Were you, or your baby's father, or any blood relative born with:
- a. ... a heart defect?  No  Yes  Not Sure
  - b. ... a cleft lip and/or cleft palate?  No  Yes  Not Sure
  - c. ... any other birth defect?  No  Yes  Not Sure
11. Have you ever had:
- ... two or more miscarriages?  No  Yes
  - ... a stillborn baby **and** one or more miscarriage(s)?  No  Yes
12. Do you, or your baby's father, or any blood relative have any other disease or health problem that is inherited (passed on in the family)?  No  Yes  Not Sure

*The next three questions will be about medical conditions that you (the patient) may have.*

13. Do you have diabetes?  No  Yes
14. Do you have, or have you ever had treatment for, PKU (phenylketonuria) or hyperphenylalaninemia (hyperphe)?  No  Yes  Not Sure
15. During this pregnancy, have you taken:
- a. seizure medication? (Dilantin, valproic acid, Depakene, Tegretol, Atretol, Mysoline, Tridione)  No  Yes
  - b. lithium (Eskalith, Lithobid, Lithonate) for bipolar disorder or depression?  No  Yes
  - c. pills (Accutane, isotretinoin) for acne?  No  Yes
  - d. chemotherapy/immunosuppressive medication? (methotrexate, aminopterin, Rheumatrex)  No  Yes

Completed by: \_\_\_\_\_

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