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 _____________

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.

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

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

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 If yes, was it a: ❐ Urine or ❐ Blood
Have you see 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 so, 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: ________ Highest grade in school completed: ________
RACE ❐White ❐Hawaiian/Other Pacific Islander ❐American Indian/Alaskan Native
❐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	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

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: WERZ-107.1 WHEB-103.1
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 or dental 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, medical. (Please fill in the information in the box below.)
- ❒ Yes, dental. (Please fill in the information in the box below.)

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

❒ **Primary Health Insurance (Please complete ALL lines below)**

Insurance Co. ______________________ Subscriber Name: ______________________
Ins. Address: ______________________ Subscriber SSN: __________ Subscriber DOB: _______
City, St, Zip: ______________________ Certificate #: __________ Group #: _______
Ins. Phone: ______________________ Effective Date: __________ 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**)? ______________________

❒ **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 #:** ______________________

❒ **Dental Insurance (Please complete ALL lines below)**

Insurance Co. ______________________ Subscriber Name: ______________________
Ins. Address: ______________________ Subscriber SSN: __________ Subscriber DOB: _______
City, St, Zip: ______________________ Certificate #: __________ Group #: _______
Ins. Phone: ______________________ Effective Date: __________ Relation to Patient: __________

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 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: ______________

PATIENT HEALTH QUESTIONNAIRE

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?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling/staying asleep, sleeping too much	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i. Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> 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
❑	❑	❑	❑

3. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

❑ Yes ❑ No

Total # Symptoms: ____________________ **Total Score**: ____________________

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Patient's Name_________________________________ Date of Birth ______/______/_______

Genetic History Questionnaire for Prenatal Patients

The answers to these questions will help in the care of your pregnancy.
Please answer these questions as well as you can. All answers will remain private.
If you need help answering the questions, please ask.

1. When your baby is born, will you be 35 years of age or older? ☐ No ☐ Yes

Where your ancestors came from may sometimes give us important information about the health of your baby.

2. Is your family…….

From Southeast Asia, Taiwan, China or the Philippines? ☐ No ☐ Yes ☐ Not Sure

From Italy, Greece or the Middle East? ☐ No ☐ Yes ☐ Not Sure

African American (Black)? ☐ No ☐ Yes ☐ Not Sure

Hispanic/Puerto Rican? ☐ No ☐ Yes ☐ Not Sure

3. Is your family, or your baby's father's family European (Ashkenazi) Jewish?
☐ No ☐ Yes ☐ Not Sure

The next nine questions will be about you, you baby's father and both of your families. When we say "blood relative" we mean your child(or unborn baby), mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew or cousin

4. Were you, or your baby's father or any blood relative born with an opening in the back or spine, also called Spina Bifida ☐ No ☐ Yes ☐ Not Sure

5. Was there ever a baby (or unborn baby) in you family or your baby's father's family who had an opening in the head, also called Anencephaly? ☐ No ☐ Yes ☐ Not Sure

6. Is any blood relative in your family or your baby's father's family mentally retarded?
☐ No ☐ Yes ☐ Not Sure

7. Have you, or your baby's father, or any blood relative had an unborn baby or a child who had Down syndrome (some call it trisomy 21)? ☐ No ☐ Yes ☐ Not Sure

8. Do you, or your baby's father , or any blood relative have any other chromosome problems?
☐ No ☐ Yes ☐ Not Sure

Ask you health care provider about multiple marker screening for Down syndrome, spina bifida, and trisomy 18, even if there is NO history of these in your or your baby's father's family

(additional questions on reverse side)

9. Do you, or does your baby's father, or any blood relative have:

a. Cystic Fibrosis (CF)? ☐ No ☐ Yes ☐ Not Sure

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:

a. Two or more miscarriages? ☐ No ☐ Yes

b. A stillborn baby **and** one or more miscarriages(s) ☐ No ☐ Yes

12. Do you, or does 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 ☐ Not Sure

14. Do you have, or have you ever been treated for PKU (phenylketonuria) or hyperphenylalaninema (hyperphe)? ☐ No ☐ Yes ☐ Not Sure

15. During this pregnancy, have you taken:

a. Seizure medications? (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, amniopterin, rheumatrex)
☐ No ☐ Yes

Providers signature________________________________ **Date**_____/_______/_______

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 patients if the 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
❐	❐	Lase dental visit was over a year ago

If you answered no to all of the above, go directly to #3

2. Screening for Symptoms Section: Date: Initials:

Yes	No	
❐	❐	Red or swolen gums
❐	❐	Bleeding in the mouth or gums
❐	❐	Gum recession
❐	❐	Signs of pus or debris between/around teeth

3. Patient Oral Care Education Section: Date: 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

4. **Follow Up:** Date: Initials:

Yes	No	
❐	❐	Patient received dental care during pregnancy

Referral to: ______________________________________ Date: ____________

Families First

support for families...health care for all

Release of Information

_____ I give my permission for the Prenatal staff to discuss my prenatal,
initial here social, and nutritional needs with Harbour Women's 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:

____

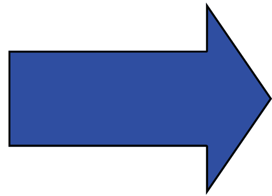
(Specify the date, event, or condition upon which this consent expires)

Signed: ______________________________ Date: ___________

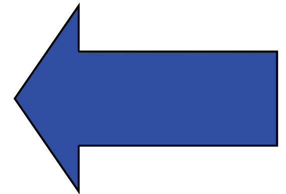
Witness: ______________________________ Date: ___________

CHILDCARE IS AVAILABLE

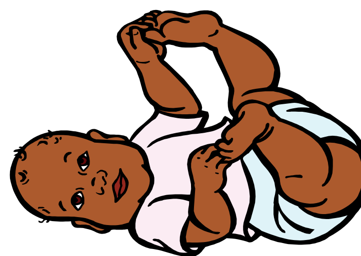
Tuesday, Wednesday & Thursday



9 AM-NOON



while you attend any appointment at Families First



Please stop by or call
the Family Center
for childcare. 422-8208 press "2"

Families First Health Center – 100 Campus Dr. – Suite 12 – Portsmouth, NH 03801
Tel: 603-422-8208 Fax: 603-422-8218
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH / MEDICAL INFORMATION

"New" Patient Release Form

PATIENT INFORMATION:

Patient Name:______________________________ Date of Birth: ______________ Phone: ________________

Address:____
Street City State Zip

PLEASE OBTAIN INFORMATION FROM:

Provider: ____________________________________

Address: ____________________________________

City, ST, Zip:_________________________________

Phone:_________________Fax: ______________

PLEASE SEND INFORMATION TO:

Provider: Families First Health Center

Address: 100 Campus Drive, Portsmouth, NH 03801

I CONSENT FOR <u>ALL</u> OF THE FOLLOWING RECORDS TO BE RELEASED:

1. Medication List
2. Problem List
3. Immunizations
4. Radiology Reports
5. Office Notes (last 3 visits)
6. Laboratory Data for the last year
7. Mammogram Results
8. Pap Smear Results
9. Colonoscopy Results

❑ Other: _______________

PATIENT/LEGAL GUARDIAN SIGNATURE:______________________________________DATE: ____________________

I give Familes First permission to share any immunization information for the above minor patient, with any school or daycare that he/she is enrolled in.

____

Patient / Guardian Signature Date

This authorization is valid for **one year** and may be revoked at any time in writing prior to the expiration date, except to the extent Families First has already used or disclosed the information in reliance on my authorization.

I understand that Families First will not condition treatment on my providing this authorization and that I may refuse to sign this authorization, unless the treatment involves research, or is performed only for the purpose of creating protected health information for disclosure to a third party (such as insurance physicals).

I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may be protected by federal or state confidentiality laws.

The purpose of this release is to transfer my healthcare

____

Patient / Legal Guardian Signature Date

____

Witness Signature Date

RELEASE OF SENSITIVE INFORMATION

I understand that my medical record may contain some information in reference to, but is not limited to, **drug and/or alcohol abuse, psychiatric treatment, venereal disease, HIV/Aids testing/information, Hepatitis B testing or treatment**.

Patient/Legal Guardian______________________________________Date ________________

Witness Signature ____Date ________________