THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

PATIENT INFORMATION/DEMOGRAPHIC FORM

Date: ____________________

PATIENT NAME: ______________________________

SSN: ______________________________

Prefer to be called / Nickname ____________________

Date of Birth: ____________ Mother's Maiden Name: ____________________

Patient Mailing Address:

Street: ______________________________

City: ____________ State: ____________ Zip: ____________

Living Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Telephone / Contact Information

Home: ____________ (Mobile # if no home phone) **Work**: ____________ (If employed) **Mobile:** ____________ (If you have a mobile #)

Email address: ______________________________

Occupation: ____________ Employer: ____________

Race:

☐ I decline to answer ☐ Caucasian/White ☐ African American/Black
☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Asian
☐ Hispanic/Latino ☐ Other Pacific Islander ☐ More than one
☐ Unsure

Ethnicity:

☐ I decline to answer ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary language spoken in household: ____________________

I acknowledge that the information is correct to the best of my knowledge.
I authorize The Family Health Centers, PA, to render treatment to me and provide information to other care givers regarding my condition while under medical care. My signature below authorizes the release of medical records to another physician involved in my care or to the insurance company for payment of claims.

______________________________ ____________________
Signature **Date**

If you are a new patient, how did you hear about us?

☐ **Doctor Referral** ☐ **Employer** ☐ **Family or Friend** ☐ **Insurance Provider**
☐ **Magazine Ad** ☐ **Street Sign** ☐ **Health Fair** ☐ **Social Media** ☐ **Google**
☐ **Yellow Pages** ☐ **Brochure** ☐ **Other** ____________________

OFFICE USE ONLY

MR #

Revised 6/2023

THE FAMILY HEALTH CENTERS
ASHEVILLE I ARDEN I HOMINY VALLEY

ADULT PATIENT HISTORY

Date: ______________________

Please complete both sides of this form.

If today's appointment is a Medicare Annual Wellness visit or a Complete Physical, we will review your preventative health needs. Should you need care for a new or ongoing medical problem, it could be addressed today, but a co-pay will be required. We may need to schedule a separate appointment.

PATIENT NAME: ______________________ Prefer to be called / Nickname ______________________

Date of Birth: ______________________

Do you have a Living Will, Health Care Power of Attorney or an Advance Care Directive? ☐ Yes ☐ No

Ask our staff if you would like Advance Care Directives information

Gender per your health insurance
☐ Male
☐ Female

If different from above, what is your current gender identity?
☐ Trans male/Trans man
☐ Trans female/Trans woman
☐ Genderqueer/Gender non-conforming
☐ Different identity – please state: ______________________

What are your personal pronouns? ______________________

What type of diet do you follow? ______________________

Do you use tobacco or other cigarettes?
☐ No, never ☐ Yes, ____ packs/day _____ age started
☐ Previously smoked___ packs/day, for___ years, stopped in ______ (year)
☐ Oral tobacco user ☐ e-cigarette / vapor cigarette user

Do you drink alcohol?
Please check the item that best describes your current consumption of alcohol:
☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times per week
☐ Previous heavy alcohol use. If stopped completely – month/year: ____________
If you drink alcohol, how much do you consume on a typical day when you are drinking:
☐1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drinks

Do you currently use street drugs (such as marijuana, cocaine, heroin, opioids or others)? ☐ Yes ☐ No

Have you ever used IV street drugs? ☐ Yes ☐ No

What is your current exercise routine? ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Who lives with you? ______________________

What is your occupation and where do you work? ______________________

Are you under any unusual stressors? ☐ Work ☐ Family ☐ Financial ☐ Illness ☐ Other

Do you use any home medical equipment? ☐ Yes ☐ No

If yes, what medical equipment and who is your supplier: ______________________

____

What form of birth control, if needed, do you use? ______________________

Number of pregnancies: _______

Sexual History: ☐ Currently sexually active ☐ With men ☐ With women ☐ With men and women
☐ Never ☐ Not active in past 12 months ☐ More than 3 partners in lifetime

CURRENT HEALTH CONCERNS (please list):

____

____

Please complete both sides of this form.

Revised 5/2018

ADULT PATIENT HISTORY *page 2*

IMMUNIZATIONS & HEALTH MAINTENANCE (give date of last shot/exam)

☐ Tetanus shot with or without Whooping Cough _________ ☐ Flu shot _________ ☐ Cholesterol test ________

☐ Pneumonia shot - Prevnar 13 or Pneumovax (if over 65) _________ ☐ Shingles shot (if over 50) _________

Colon Cancer Screening (if over 50) ☐ Stool Test _______ ☐ Colonoscopy ________ ☐ Sigmoidoscopy ________

☐ If smoking history, last lung cancer screening / CT scan (if 55 to 80) _________

Women only: (please give date of last exam)

☐ Mammogram __________ ☐ Last Period __________ ☐ PAP Smear _________ ☐ Bone Density __________

Men only: (Please give date of last exam) ☐ PSA test __________

Allergies to medications and the reaction you had: ____

New Patients: list all medications. **Current patients:** list any new medications. (Include non-prescription.)
Please ask for a second sheet if needed

Medication	Dose	How often

Medical history (Any illness for which you have received a diagnosis):

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Back Problems ☐ Chronic Pain ☐ COPD / Emphysema ☐ Depression
☐ Diabetes ☐ Fibromyalgia ☐ Reflux / Heartburn ☐ High Cholesterol ☐ Heart Disease/Stroke
☐ High Blood Pressure ☐ History of Cancer Type(s) _____________ ☐ Kidney Disease ☐ Thyroid Disorder

Other: ____

List previous surgeries: ____

Family History of Major Medical Problems (if deceased, list cause and age of death)

Father: ____

Mother: ____

Brothers/Sisters: ____

Circle any of the following symptoms you currently experience

General	Appetite changes, chills, fatigue, fever, night sweats, weight gain, weight loss
Skin	Changes in wart/mole, new lesions, rash
HEENT	Eye exams by ophthalmologist or optometrist, glasses or contact lenses, headache, head injury, hearing loss, hoarseness, disturbances
Neck	Neck mass, neck pain
Respiratory	Shortness of breath, cough, coughing with blood, snoring
Breast	Breast mass, breast pain, nipple discharge
Cardiovascular	Chest pain, difficulty breathing lying down, difficulty breathing on exertion
Gastrointestinal	Abdominal pain, black stool, tarry stool, bloody stool, constipation, diarrhea, difficulty swallowing, indigestion, nausea
Female Genito-urinary	Blood in urine, change in bladder habits, painful urination, hot flashes, menstrual irregularities, painful menstruation, are you in Menopause Yes_______ No _______
Male Genito-urinary	Blood in urine, change in bladder habits, painful urination, sexual difficulty, discharge from penis, urine leakage
Musculoskeletal	Back pain, joint pain, muscle weakness, swelling of extremities
Neurological	Dizziness, falls, loss of consciousness, stroke-like symptoms, seizures, falling, trouble walking
Psychiatric	Change in sleep pattern, depression, insomnia, mood changes, nervousness
Endocrine	Heat or cold sensitivity, excessive thirst, hunger or urination
Hematology	Easy bruising, easy bleeding, enlarged lymph nodes

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

EMERGENCY CONTACT & HIPAA FORM

Date: ________________________ **MRN:** ________________________

PATIENT NAME: ______________________________________ Date of Birth _____ / _____ / _______

Healthcare Insurance Portability and Accountability Act (HIPAA) information

By signing this form, you authorize The Family Health Centers to release protected health information for the above-named patient according to the instructions below.

If unable to reach the patient via telephone, we may (please check all that apply):

- ☐ Leave a detailed voice message
- ☐ Leave a voice message asking you to return our call
- ☐ Do not leave a voice message
- ☐ Mail a post card or letter

I have read and fully understand The Family Health Centers, PA's Privacy Notification. I have the right to revoke this authorization at any time. I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to The Family Health Centers. A revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

I authorize this information to be released to:

Name: ______________________________________ ☐ Emergency Contact
Relationship: ______________________________________ ☐ Billing/Financial Information
Phone #: ______________________________________ ☐ Medical Information

Name: ______________________________________ ☐ Emergency Contact
Relationship: ______________________________________ ☐ Billing/Financial Information
Phone #: ______________________________________ ☐ Medical Information

Name: ______________________________________ ☐ Emergency Contact
Relationship: ______________________________________ ☐ Billing/Financial Information
Phone #: ______________________________________ ☐ Medical Information

Signature: ____ Date: ________________

Description of patient representatives' authority, if applicable ______________________________

____

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

Date: ____________________

Please review this **Financial Policy** and sign in the space provided.

1. Please complete all forms provided and be prepared to present your driver's license and current insurance card at the time of your visit. It is YOUR responsibility to provide us with your most current mailing address, phone number and insurance information.
2. We participate with many insurance plans, including Medicare. Understanding your plan benefits and what services are or are not covered is your responsibility. If we provide services at a Wellness Visit that are not covered by your insurance or Medicare, extra charges and a copay may appear on your bill. Contact your insurance company directly for any questions you might have regarding your coverage.
3. Please check our website for our participation list. If your insurance plan is not listed, payment in full is expected at time of service.
4. Co-payments and deductibles are due at time of service. We accept: cash, check, debit and major credit cards, including Care Credit.
5. Please be advised that some services you receive may be designated as non-covered or not necessary by Medicare or other insurers. Payment for these services is also expected at time of service.
6. We submit claims to insurance carriers promptly. Your insurance company may require additional information directly from you to pay your claim. It is your responsibility to provide this as timely as possible. Whether your insurance pays all or part of the claim, it is ultimately your responsibility to pay any balance due after insurance processes your claim.
7. If your insurance coverage changes, please notify us before your next visit so we can make the change in our system.
8. If you do not have health insurance, the Family Health Centers offers a 30% discount on select services ONLY if payment in full is made at the time of the visit.
9. If a balance due on your account is 90 days or older, your account will be moved to a collection process. You will receive a final letter offering an opportunity to pay the debt. If payment is not made, your account may be turned over to a collection agency and you may be dismissed from the practice. If this occurs, you will be given 30 days to find alternative medical care. During that 30-day period your FHC provider will only be able to treat you on an *emergency* basis.
10. **If you use a check for payment, you agree to the following terms:** If your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount, plus any applicable fees as permitted by state law.

    Our practice is committed to providing high quality care to the patients. Please let us know if you have any questions or concerns.

I have read, understand and agree to abide by the above financial policy.

______________________________	______________________________
Signature of Patient/Responsible Party	Printed Name of Patient/Responsible Party
______________________________	______________________________
Signature of FHC Employee	MR #