

New Patient – Adult

New Patient: Medical Dental

Name: _____ Preferred Name: _____
First MI Last

DOB: _____ Birth Gender: Male Female

Mailing Address: _____ City/State/Zip: _____

Physical Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Communication Preferences: *(for appointment reminders, etc.)*

Language: English Spanish

Type: *(choose one)* Voice Text Contact Number: *(choose one)* Home Cell Work

Email Address: _____

Emergency Contact Information:

Name: _____ Date of Birth: _____

Relationship to Patient: _____ Home Phone: _____ Cell: _____

Emergency Contact has permission to be on patient Release of Information: Yes No

Responsible Party: Self Other (If other, please provide letter of Guardianship or POA.)

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____ Phone Number: _____

Pharmacy: _____
Name Location/Address

Primary Medical Provider: (This is the provider you will see on a regular basis). _____

Language: English Spanish ASL Other: _____ Interpreter: Yes No

Marital Status: Single Married Separated Divorced Widowed

<p>Race: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro Somoan <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Decline to Specify</p>	<p>Ethnicity: <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Total Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Not Hispanic, Latino/a or Spanish Origin <input type="checkbox"/> Decline to Specify</p>
--	--

Advanced Directive: Yes No (If yes, please provide documentation to be placed in chart.)

Living Will Declaration Physician Ordered Scope of Treatment

Employment Status: Full-time Part-time Unemployed Self-employed Student Retired
Employer: _____

Gender Identity: Male Female Transgender Male Transgender Female
 Additional Category Choose Not to Disclose

Sexual Orientation: Straight Gay/Lesbian Bisexual Something Else Don't Know
 Choose Not to Disclose

Health Insurance Information: Do you have? Yes No – ask us about our Sliding Fee Discount

Primary Insurance: _____ *Policy Number:* _____

Group Number: _____ *Policy Holder (Who carries the insurance):* _____

Policy Holder Date of Birth: _____ *Relationship to Patient:* _____

Secondary Insurance: _____ *Policy Number:* _____

Group Number: _____ *Policy Holder (Who Carries the Insurance):* _____

Policy Holder Date of Birth: _____ *Relationship to Patient:* _____

Military Veteran: Active Veteran N/A **Homeless:** Yes No **Migrant Worker:** Yes No

How did you learn of Valley Professionals? TV/Radio Google Facebook

Family/Friend Other: _____

Number of People in Household: _____ **Annual Income** _____

Medical History:

Our electronic medical record system allows us to review, collect and share your medical history including medications, testing and treatment plans. This information is collected from various sources, including your pharmacy, healthcare plan and other healthcare providers. Knowing this information allows our providers to treat you properly improving your experience and decreasing risk. This information will become part of your medical record. You have the right to request a restriction on the ways your personal healthcare information is used or disclosed. All requests should be submitted in writing to Valley Professionals.

Release of Information:

I hereby authorize Valley Professionals Community Health Center to release/discuss my protected health information with the following individuals:

Name: _____ Relationship: _____ Contact number: _____

Name: _____ Relationship: _____ Contact number: _____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to Valley Professionals. If I revoke the authorization, this will not apply to any information that has already been released based on the authorization or to information that Valley Professionals has used based on the authorization. For questions on the use and disclosure of information, I can contact Valley Professionals.

Name: _____

Date of Birth: _____

Health History

Valley Professionals Community Health Center (VPCHC) uses a team-based approach to healthcare that works at improving care by providing comprehensive and continuous medical care. Our comprehensive care covers prevention and wellness, acute and chronic care as well as mental health and dental. In order to provide the best patient care possible, it is essential that the information below be provided to ensure your healthcare team understands your specific health concerns/needs. Each patient's provider and care team work to support the patient in learning to manage and organize their own care. In addition, the care team coordinates patient care with specialty groups, hospitals, home health and community services to ensure continuous, uninterrupted care.

Please complete the following information for your care team.

Health Conditions: *Do you have, or have you had?*

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Substance Use Disorder | <input type="checkbox"/> Kidney Disease/Dialysis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Other: _____ | |

Allergies:

- | | | |
|---|---|--|
| Metal <input type="checkbox"/> Yes <input type="checkbox"/> No | Local Anesthetic <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medication <input type="checkbox"/> Yes <input type="checkbox"/> No | Environmental <input type="checkbox"/> Yes <input type="checkbox"/> No | Food <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes for any, please list specifics: _____

Medications: Have you ever taken Fosamax, Boniva, Actonel, etc.? Yes No

Please list all medications including over the counter and herbals. _____

Hospitalizations & Surgeries:

Women Only:

Taking/using contraceptives? Yes No Pregnant? Yes No Nursing? Yes No

Dental Only:

Do you have a primary dentist outside of VPCHC? Yes No *If yes, who:* _____
 Does dental treatment make you nervous/anxious? Slightly Moderately Extremely No
 Do you need to take medication prior to treatment? Yes No *If yes, are you taking?* Yes No

*****By signing below, I confirm that the information provided is correct to the best of knowledge.**

Patient Signature Date

*****By my signature below, I acknowledge that I have received the Patient Bill of Rights and a Notice of Privacy Practice.**

Patient Signature Date