Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

New Patient – Adult

New Patient: ☐Medical ☐Dental

Name:_____ Preferred Name: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Physical Address: _____ City/State/Zip: _____

Communication Preferences: *(for appointment reminders, etc.)* Language: ☐English ☐Spanish

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

Email: _____ Birthdate: _____

Birth Gender: ☐Male ☐Female

Responsible Party: ☐Same as above ☐Different from patient *(please complete below)*

Name:_____ Birthdate: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Relationship to Patient: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell: _____

Additional Information: Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

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

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

Primary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder (Name on card): _____

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

Secondary Insurance: _____ Policy Number: _____

Group Number: _____ Policy Holder (Name on card): _____

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

By signing below, I confirm that the information above is correct to the best of my knowledge:

_____

Patient Signature Date

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Valley Professionals is a Federally Qualified Health Center that receives government funding. The funding for the health center is based on the information you provide and is necessary for us to serve our patients. Please complete the following information for reporting purposes.

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American ☐White ☐American Indian/Alaska Native ☐More Than One Race ☐Choose Not to Disclose

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Choose Not to Disclose

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

Advanced Directive: ☐Yes ☐No

(If yes, select all that apply.) ☐Do Not Intubate ☐Do Not Resuscitate ☐Living Will Declaration ☐Health Care Representative Appointment ☐Life Prolonging Procedures Declaration ☐Physician Ordered Scope of Treatment

Military Veteran: ☐Yes ☐No **Homeless:** ☐Yes ☐No **Migrant Worker:** ☐Yes ☐No

How did you learn at Valley Professionals? ☐TV/Radio ☐Google ☐Facebook ☐Family/Friend ☐Other: _____

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

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

Pharmacy: _____
Name Location/Address

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.

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

_____
Patient Signature Date

Valley Professionals Community Health Center
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Name: _____ **Date of Birth:** _____

Health History

Valley Professionals Community Health Center (VPCHC) uses a team-based approach to healthcare thatworks 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?*

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

Allergies:

Metal ☐Yes ☐No	Local Anesthetic ☐Yes ☐No	Latex ☐Yes ☐No
Medication ☐Yes ☐No	Environmental ☐Yes ☐No	Food ☐Yes ☐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 above is correct to the best of my knowledge:

_____

Patient Signature Date