Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

New Patient – Adult

New Patient: ☐ Medical ☐ Dental

Name: ____ Preferred Name: _____________________
First MI Last

Date of Birth: ___________________ Birth Gender: ☐ Male ☐Female

Mailing Address: _____________________________________ City/State/Zip: ______________________

Physical Address: _____________________________________ City/State/Zip: ______________________

County: _____________________ Home Phone: _____________________ Cell: _____________________

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

Race: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro Somoan ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ Other ☐ Decline to Specify	**Ethnicity:** ☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish Origin ☐ Total Hispanic, Latino/a or Spanish Origin ☐ Not Hispanic, Latino/a or Spanish Origin ☐ Decline to Specify

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 treatyou 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 healthinformation 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.

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

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

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

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

____
Parent/Guardian Signature Date

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

____
Parent/Guardian Signature Date