Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

New Patient – Child

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

Birthdate: _______________________ Birth Gender: ☐Male ☐Female

Responsible Party:

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:

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:

____

Parent/Guardian Signature Date

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

Student Status: ☐Full-time ☐Part-time ☐Not a Student School: ________________________

Foster Care: ☐Yes ☐No **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** _________________________

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.

Treatment of a Minor:

I give my permission for my child to be medically evaluated and treated at Valley Professionals in my absence. In addition, I give permission for the provider to share any relevant health information with the person accompanying my child. My child will be accompanied by:

☐Himself or herself (only if 16 years or older)

☐Relative/family member: Name __________________________ Relationship: ________________

☐Other: Name _______________________________ Relationship: __________________

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.

____
Parent/Guardian 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: ______________________________

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____

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

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

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Hospitalizations & Surgeries:

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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:

____

Parent/Guardian Signature Date