Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

New Patient – Child

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

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

Foster Care: ☐Yes ☐No **If yes, please provide letter of Guardianship.**

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

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

Employer: _____

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Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other ☐Choose Not to Say

Sexual Orientation: ☐Straight ☐Gay/Lesbian ☐Bisexual ☐Other ☐Unsure ☐Choose Not to Say

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

Primary Insurance: _____ ID Number: _____

Group Number: _____Policy Holder (who carries insurance): _____

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

Secondary Insurance: _____ ID Number: _____

Group Number: _____Policy Holder (who carries insurance): _____

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

Military Status: ☐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** _____

****Treatment of a Minor (person permitted to bring patient for treatment without parent or guardian):**

I give my permission for my child to be receive medical treatment 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: (Check all that apply.)

☐Relative/family/friend (must be 18 years or older) ☐Himself or herself - only if 16 years or older

Name _____ Relationship: _____

Name _____ Relationship: _____

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.

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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

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*****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