FAMILY MEDICAL CENTERS

PATIENT REGISTRATION INFORMATION FORM

DATE REC/ENTERED: _____

STAFF INITALS: _____

APPOINTMENT TYPE/STAFF USE ONLY ◯ Medical ◯ Dental ◯ Behavioral Health

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	SOCIAL SECURITY #:

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

MARITAL STATUS

◯ Single ◯ Widowed
◯ Married ◯ Separated
◯ Divorced ◯ Partner

PREFERRED CONTACT METHOD

◯ Primary Phone
◯ Cell Phone
◯ Work Phone
◯ E-Mail

PRIMARY PHONE

CELL PHONE

WORK PHONE

E-MAIL ADDRESS

PRIMARY LANGUAGE ***(if not English)***

GENDER INFORMATION

BIRTH GENDER ◯ Male ◯ Female

GENDER IDENTITY

◯ Male
◯ Female
◯ Other
◯ Trans-Male to Female
◯ Trans-Female to Male
◯ Choose Not to Disclose

DO YOU THINK OF YOURSELF AS (Check all that apply)

◯ Straight/Heterosexual
◯ Lesbian, Gay or Homosexual
◯ Bisexual
◯ Other
◯ Choose Not to Disclose

RACE INFORMATION

If you identify with more than one race, please mark all that apply

◯ Asian
◯ Alaskan Native
◯ Native Hawaiin
◯ White/Caucasian
◯ American Indian/Native American
◯ Black/African American
◯ Pacific Islander
◯ Choose Not to Disclose

ETHNICITY INFORMATION

◯ Hispanic/Latino ◯ Not Hispanic/Latino ◯ Choose Not to Disclose

EMERGENCY CONTACT

Please give us the name of one person we can call if we cannot reach you and have important medical/dental information we need to inform you of immediately, (i.e., test results).

NAME	PHONE	RELATIONSHIP TO YOU	Does this person know you are an FMC patient? ◯ Yes ◯ No

PHARMACY INFORMATION

NAME OF PATIENT'S FIRST CHOICE OF PHARMACY	PHARMACY ADDRESS
NAME OF PATIENT'S SECOND CHOICE OF PHARMACY	PHARMACY ADDRESS

ADDITIONAL PARENT/GUARDIAN INFORMATION

NAME	PHONE	Street Address	City, State, Zip
NAME	PHONE	Street Address	City, State, Zip

RESPONSIBLE PARTY INFORMATION

If the primary insurance subscriber is not the patient than please provider the information of the policy holder.

LAST NAME	FIRST NAME	MI	PHONE NUMBER	DATE OF BIRTH

RELATIONSHIP TO PATIENT	SOCIAL SECURITY #:

EMPLOYMENT INFORMATION

◯ Employed ◯ Retired ◯ Disabled ◯ Full-Time Student

◯ Unemployed ◯ Other ◯ Military (National Guard or Veteran) ◯ Part-Time Student

VETERAN/MILITARY INFORMATION

Is or was the patient ever a member of the US MILITARY or is the patient an US VETERAN? ◯ Yes ◯ No

HOUSING STATUS

ARE YOU HOMELESS? ◯ Yes ◯ No IF SO, ARE YOU: ◯ Doubled-Up (Living with others) ◯ Shelter ◯ Street ◯ Transitional

INCOME INFORMATION

In order for Family Medical Centers to help our patients, we must ask everyone to complete the following information. This is required so that FMC can receive Federal grant dollars to serve our patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

Total number of people in your household, including yourself: _____

Total household income: *(Please estimate the amount that best describes the total income in your household.)* _____

AUTHORIZATION & RELEASE

VERIFICATION OF INFORMATION *(Must be signed before submitting)*

I authorize my insurance benefits be paid directly to the Family Medical Centers. I understand that I may be responsible for non-covered charges. I also authorize the Family Medical Centers to release any information required to process this claim. Furthermore, I authorize any information regarding my care to be shared between all the Family Medical Centers services. I also authorize Family Medical Centers providers to access my prescription history so they can check for possible drug interactions or avoid prescribing medications you may be allergic to.

SIGNATURE: _____ DATE: _____

This next section is for parents/guardians with a child needing services at any FMC Center.

FOR MINORS NEEDING SERVICES

Is your child a current Family Medical Center Center (FMC) patient? ◯ Yes ◯ No If yes, by what provider? _____

By signing this consent, I agree for my child to receive Medical, Dental, Behavioral Health and Telehealth programs. I agree to the terms and conditions regarding Payment for Services and & Sharing of Health Information as explained in the accompanying Program Description form. I have also also received and agree with the Patient Consent for use and Disclosure of Protected Health Information as explained in the Program Description form. I have had the opportunity to review the Notice of Privacy Practice. I understand and agree that this consent will remain in effect until I revoke it or until my child is no longer enrolled in a school district where FMC provides services.

SIGNATURE: _____ DATE: _____

Please check mark which services you would like your child to participate in:

◯ Medical

◯ Behavioral Health

◯ Dental

◯ No Services

NOTE: School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center services or not.

FAMILY MEDICAL CENTERS

Today's Date: _____

New Patient History

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Medical and Social History

Date of last colonoscopy?	Date of last Mammogram?	Date of last Pap smear?

Do you drink alcohol? ☐ Yes ☐ No

Do you use any of these tobacco products? ☐ Cigars ☐ Cigarettes ☐ Smokeless tobacco ☐ Vape

Have you or are you currently doing any illicit drugs? ☐ Yes ☐ No

Womens Health History

Menstrual/Sexual History:

Do you have periods? ☐ Yes ☐ No	Age when you started?	Are your periods ☐ Regular ☐ Irregular

Contraceptive History:

Current Method of Birth Control?	Any Problems? ☐ Yes ☐ No	Do you wish to continue your current method? ☐ Yes ☐ No

Pregnancy History:

No. of pregnancies?	No. of births?	Age at first pregnancy?

Living Children?	Miscarriages?	Abortions?	Complications? ☐ Yes ☐ No

Pediatric Patients Only

Mother's age at pregnancy?	Illness during pregnancy? ☐ Yes ☐ No	Complication during birth? ☐ Yes ☐ No

Any medications during pregnancy? ☐ Yes ☐ No

At birth, did your baby have trouble with any of the following? ☐ Breathing ☐ Jaundice ☐ Infection

Was your pregnancy full term? If not, how many weeks?

Type of delivery? ☐ Vaginal ☐ Forceps ☐ C-Section

Please answer the following: ☐ Breast fed ☐ Formula fed

Any Colic or feeding problems during the first 3 months? ☐ Yes ☐ No

Psychiatric Patients Only:

How were you referred to us? ☐ Medical Provider ☐ Self ☐ Family/Friend ☐ Other (Specify) _____

If it a medical provider please state who:

Have you had any previous psychiatric hospitalizations? ☐ Yes ☐ No

Have you previously been prescribed medications for mental health? ☐ Yes ☐ No

What is your goal for today's visit?

Pediatric Dental Patients Only:

At what age did bottle or breast feeding stop?

Did your child ever suck their fingers or thumb? ☐ Yes ☐ No

Does the patient use fluoride rinse? ☐ Yes ☐ No

Who is responsible for brushing your child's teeth?

What source is the patient's current drinking water supply? ☐ City ☐ Home Well ☐ Bottle ☐ Don't Know

Are the patient's immunizations up to date? ☐ Yes ☐ No

FAMILY MEDICAL CENTERS

New Patient Medical/Dental History

Patient Name: _____

Date of Birth: _____

Previous Medical Provider & Location

_____

_____

Previous Dentist & Location

_____

_____

Previous Psychiatric/Mental Health Provider

_____

Current or Previous Counselor

_____

Allergies	**Reactions**	**Current Medications:**	**Dosage:**

Please check the appropriate box if you or a family member has had any of these medical conditions

Problem	**You**	**Family**
Anemia	☐	☐
Arthritis	☐	☐
Allergies (Seasonal)	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding or Clotting Abnormality	☐	☐
Blood Disorder	☐	☐
Birth Defects or Genetic Disorders	☐	☐
Bone/Joint Problems	☐	☐
Bowel/Stomach Problems	☐	☐
Cancer	☐	☐
Chicken Pox	☐	☐
Cholesterol Problems	☐	☐
Circulatory Problems	☐	☐
Cerebral Palsy	☐	☐
Dental Issues	☐	☐
Diabetes	☐	☐
Developmental Problems	☐	☐
Eczema/Hives	☐	☐
Edema	☐	☐
Epilepsy/Seizures	☐	☐
ENT/Ear, Nose and Throat Problems	☐	☐
Growth Problems	☐	☐
GYN Issue	☐	☐
Headaches / Migraines	☐	☐
Head Injury	☐	☐
Heart Problems	☐	☐
Liver Disease / Hepatitis	☐	☐
Neurological Problems	☐	☐

Problem	**You**	**Family**
High Blood Pressure	☐	☐
HIV/AIDS	☐	☐
Kidney/Bladder/Prostate Problems	☐	☐
Meningitis	☐	☐
Pacemaker	☐	☐
Recurrent Infections	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Sleep Problems	☐	☐
Stroke	☐	☐
Thyroid Problems	☐	☐
Tuberculosis	☐	☐
Vision Problems	☐	☐

Other Medical Problems (Specify) _____

If any of the following pertain to you, please let us know the age you were diagnosed

Depression	☐	☐	Age _____
Behavior Issue	☐	☐	Age _____
Anxiety	☐	☐	Age _____
Eating Disorder	☐	☐	Age _____
Post-Traumatic Stress Disorder	☐	☐	Age _____
Mood Disorder	☐	☐	Age _____
Bipolar Disorder	☐	☐	Age _____
Schizophrenia	☐	☐	Age _____
Obsessive Compulsions Disorder	☐	☐	Age _____
Substance Use Disorder	☐	☐	Age _____
Personality Disorder	☐	☐	Age _____
ADHD/ADD	☐	☐	Age _____
Autism Spectrum Disorder	☐	☐	

Please check if you have had any of the following dental problems

Bad Breath	☐	Periodontal Treatment	☐	Injuries to Mouth or Teeth	☐	Toothache/Pain	☐
Bleeding Gums	☐	Sensitivity to Hot/Cold	☐	Sensitivity to Sweets	☐	Abscesses (Gum Boils)	☐
Clicking or Popping Jaw	☐	Loose Teeth or Broken fillings	☐	Sensitivity to Biting	☐	Other (Specify) _____	
Grinding Teeth	☐	Sores or Growths in Mouth	☐	Food Collection Between Teeth	☐	_____	

Patient Preferred Communication Method

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

What ways can we contact you? (Check all that apply)

☐ Phone ☐ Text ☐ Email ☐ Opt out of all communication

Please check yes or no to the following questions so that we can contact you in the most efficient way possible.

If you have an answering machine at home, may we leave a message?	☐ Yes	☐ No
May we mail written communication to your home address?	☐ Yes	☐ No
May we leave a message at your work for you to call our office?	☐ Yes	☐ No
Is there a person at your house that we may leave a message with?	☐ Yes	☐ No

List below any person/persons authorized by you to discuss/receive/access your medical information:

	First Name:	Last Name:	Relationship to Patient:
1.			
2.			
3.			

To comply with Ohio Law, the Family Medical Centers require that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

List below any person/persons authorized by the parent/guardian to consent to any and all necessary Medical/Mental Health Treatment/Dental and Surgical Care and Treatment at Family Medical Centers for the maximum period of one year.

	First Name:	Last Name:	Relationship to Patient:
1.			
2.			
3.			

During the period (not to exceed a maximum of 1 year):

Date (month/day/year): _____ **From:** _____ **To:** _____

By signing below, I authorize FMC to use/disclose my health information in a manner consistent that stated in the Notice of Privacy Practices that I have received.

Patient Signature: _____ **Date:** _____

Guardian's Name: _____ **Relationship to Patient:** _____

Parent or Guardian Signature: _____ **Date:** _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Note: Uses and disclosures for Treatment, Payment, and Healthcare Operations (TPO) may be permitted without prior consent.

Consent for Evaluation and Treatment

Family Medical Centers (FMC) is dedicated to providing comprehensive primary health, dental and behavioral health services. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you high-quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

Some services at Family Medical Centers may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet, or saved in any way.

I understand and consent to the evaluation and treatment of depression, anxiety, attention deficit hyperactivity disorder, autism spectrum disorder, gender-related conditions, oppositional defiant disorder, conduct disorder, bipolar disorder, personality disorders, and gender dysmorphia; as well as physical, sexual, mental, and emotional abuse and other traumas.

By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me and that I understand it and that any questions I asked have been answered.

Thus, I hereby ask, agree, and consent to screening, evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that FMC professional staff deem necessary or appropriate. If signing as a parent, custodian, or legal guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

My signature below serves to confirm I have received information on how to obtain a copy of the Family Medical Centers' Notice of Privacy Practices as well as the Patient Rights and Responsibilities.

Name of Patient:_____

Signature of Patient or Patient Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____