ALLIANCE FAMILY HEALTH CENTER

Primary Care Patient Registration

Legal Name:_____ **Date of Birth**:_____ **SS#**: ___-___-____

Preferred Name: _____ **Preferred Language:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

Pharmacy:_____ **Email:** _____

Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐White ☐Black/African American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander

Home Phone: (_____) _____-_____ **Cell Phone:** (_____) _____-_____

Preference for appointment reminders:
Consent to call (circle): *YES* *NO* Consent to text (circle): *YES* *NO*

May we leave a message on answering machine concerning:
Results of Tests (circle): *YES* *NO* Appointments (circle): *YES* *NO*

Why do we ask lifestyle questions? Because we treat uninsured and underinsured patients, we are required to report certain demographics on **ALL** patients. Reported information will not contain your name, address, or social security number. Blank answers will be noted as declined.

Please check any which apply

Sexual orientation: ☐Heterosexual (Straight) ☐Homosexual (Gay or Lesbian) ☐Bisexual ☐Other ☐Unsure

Gender identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Gender Queer ☐Other

Preferred Pronoun (*Example: He, She, Him, Her, It, Etc.*): _____

Are you a veteran: ☐Yes ☐No **Are you homeless:** ☐Yes ☐No

Agricultural worker: ☐Yes ☐No **Public housing patient:** ☐Yes ☐No

What is your current family size (living in household): _____

What is your current estimated income: $_____ (YEARLY MONTHLY BI-WEEKLY WEEKLY)

How did you hear about us? _____

1401 S. Arch Ave · Suite A · Alliance, OH · 44601
Phone: (330) 596-7581 Fax: (844) 269-4253

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Insurance Information

Primary Insurance Name_____
Member I.D. # _____ Group #_____
Policyholder Name _____ Date of Birth _____
SS # _____-_____-_____ Policyholder Employer _____
Patient's Relationship to Policyholder (*Check one*) _____Self _____Spouse _____Dependent

Secondary Insurance Name _____
Member I.D. # _____ Group # _____
Policyholder Name _____ Date of Birth _____
SS # _____-_____-_____ Policyholder Employer (if different) _____
Patient's Relationship to Policyholder (*Check one*) _____Self _____Spouse _____Dependent

EMERGENCY CONTACT INFORMATION: Please give the name and phone number of a responsible person that you give permission for our office to contact in case of an emergency.

_____

Name Relationship Phone #

RELEASE OF INFORMATION: Please give the name and phone number of a responsible person you authorize to use, receive and/or disclose your protected health information

_____

Name Relationship Phone #

I am authorizing treatment for the above patient. This treatment may include administration of medications, diagnostic testing, and X-ray examinations, or other treatment as deemed necessary by the attending physician. I authorize the release of any medical or other information necessary to process claims on my behalf. I authorize my insurance benefits (included authorized Medicare benefits, if applicable) be paid directly to Alliance Family Health Center (AFHC) for any services furnished. To provide continuity of care, I authorize the release of medical information to specialty physicians under contract with AFHC. I understand that I am responsible for all co pays, deductibles, and co insurance. Furthermore, if I am not eligible for insurance, I am responsible for full payment of services rendered. I acknowledge that I have been notified that the Notice of Privacy Practices of AFHC, which sets forth the ways in which my protected health information may be used or disclosed by AFHC, and outlines my rights with respect to such information. I have been provided the opportunity to request a paper copy of this notice as well as information on how to view the notice electronically on the website at www.alliancefamilyhealth.org. I give permission for AFHC Physicians to obtain my medication history, benefits, and formulary information from my pharmacy on file.

_____ _____

Patient Signature Date

_____ _____ _____

Parent/Guardian Signature Date Relationship if not signed by patient

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PATIENT'S PAST MEDICAL HISTORY

Please check yes to each which apply to patient:

	Yes		Yes		Yes
Acid Reflux (GERD)		Cancer		Heart condition/problems	
Addiction		COPD		High cholesterol	
ADHD		Coronary Artery Disease (CAD)		Hypertension	
AIDS/HIV		Depression		Kidney disease	
Allergies (Seasonal)		Diabetes		Liver disease	
Anemia		Hearing problems		Lung disease	
Anxiety		Eating disorder		Muscle, joint or bone problem	
Arthritis		Fibromyalgia		Osteoporosis	
Asthma		GI problems		Seizures/epilepsy	
Autism Spectrum Disorder (ASD)		Gout		Skin problems	
Bladder problems		Headaches/Migraines		Thyroid problems	
Bleeding disorder		Heart disease		Vision/Eye problems	
OTHER					

Has the patient ever had any surgeries or hospitalizations? ☐YES ☐NO

If yes, please list with date: _____

_____

Does the patient have any allergies to medications, substances, or food? ☐YES ☐NO

If yes, please list all allergies: _____

CURRENT MEDICATIONS

Medication Name	Dose	Who prescribed medication (*Provider or Specialty*)

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FAMILY MEDICAL HISTORY

Please list any immediate family medical history
(*example: Cancer, Diabetes, Hypertension*)

	Medical History		Medical History
Mother		Father	
Sister		Brother	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	
Maternal Aunt(s)		Paternal Aunt(s)	
Maternal Uncle(s)		Paternal Uncle(s)	

SOCIAL AND OTHER HISTORY:

Does the patient use tobacco products? [ ] YES [ ] NO If yes, how much per day?_____

Does the patient drink alcohol? [ ] YES [ ] NO If yes, how many drinks per week?_____

Does the patient use any illegal substance? [ ] YES [ ] NO If yes, what kind and frequency_____

WOMEN'S HEALTH INFORMATION ONLY

Last menstrual cycle: _____ Current form of birth control: _____

Last Pap smear: _____ Was it abnormal? ☐YES ☐NO

Last mammogram: _____ Was it abnormal? ☐YES ☐NO

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