"CARING FOR OHANA, CARING FOR YOU"

PATIENT INFORMATION

First Name: ______________________________ MI: _____ Last Name: ________________________________

Mailing Address: ___________________________ City: ___________________ State: ___ Zip code: __________

Residence Address: _________________________ City: ___________________ State: ___ Zip code: ___________

Home phone: (___) _____-_________ Work Phone: (___) _____-________ Mobile Phone: (___) _____-________

E-mail Address: ____

Date of Birth: __ __/__ __/ __ __ __ __ Social Security Number: __ __ __- __ __- __ __ __ __ Gender: [ ] F [ ] M

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Employer: ____________________ Address: __________________ City: _____________State: ___ Zip code: ________

RESPONSIBLE PARTY INFORMATION

First Name: ______________________________ MI: _____ Last Name: ________________________________

Mailing Address: ___________________________ City: ___________________ State: ___ Zip code: __________

Residence Address: _________________________ City: ___________________ State: ___ Zip code: ___________

Home phone: (___) _____-_________ Work Phone: (___) _____-_________ Mobile Phone: (___) _____-_________

Date of Birth: __ __/__ __/ __ __ __ __ Social Security Number: __ __ __- __ __- __ __ __ __ Gender: [ ] F [ ] M

Relationship to patient: _________________________________

Employer: ____________________ Address: __________________ City: _____________State: ___ Zip code: _______

The co-pays or charges are based on an estimated charge and will be fully documented by your provider after the visit. Any additional charges not covered by your insurance may be billed to you.

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Insurance Carrier: ______________________________	Insurance Carrier: ______________________________
Subscriber Name: ______________________________	Subscriber Name: ______________________________
Subscriber Number: ____________________________	Subscriber Number: ____________________________
Mailing Address: ______________________________	Mailing Address: ______________________________
______________________________	______________________________
Subscriber's Date of Birth: __ __ /__ __/ __ __ __ __	Subscriber's Date of Birth: __ __ /__ __/ __ __ __ __

PHARMACY INFORMATION

Preferred Pharmacy Name: ______________________________________ Location: _________________________

"CARING FOR OHANA, CARING FOR YOU"

ADDITIONAL INFORMATION

As a Federally Qualified Health Center we are required to annually report on the populations we serve. The next set of questions is necessary to obtain the information we need for reporting. Please remember that your answers are strictly confidential.

Which of the following income categories best describes the total monthly income for your family?

$0-$900	$1,000-$1,900	$2,000-$2,900
$3,000-$3,900	$4,000-$4,900	$5,000-$5,900
$6,000-$6,900	$7,000-$7,900	$8,000+

How many people are supported by that income? ________________

What sex were you assigned at birth?

Male Female

Which of the following do you consider yourself to be?

Straight or Heterosexual Gay or Lesbian Bisexual

What is your Gender Identity?

Male Transgender Male

Female Transgender Female Other: ____________________________

Are you homeless?

Yes No

Primary Language (Select One):

English	Spanish	Tagalog	Ilocano	Hawaiian
Marshallese	Japanese	Chinese	Sign	Other: ____________________

Do you need an Interpreter?

Yes No

What is your Most Prominent Ethnicity (Select One)?

Caucasian	Japanese	Hawaiian	Filipino	Chinese	Korean
Portuguese	Samoan	Pacific Islander	Marshallese	Puerto Rican	Micronesian
American Indian	African American	Vietnamese	Other Asian	Hispanic	Other

Citizenship Status: US Citizen Immigrant Permanent Resident/Alien Other: _______________

Are you Hispanic? Yes No **Are you a...** Veteran Non-Veteran

Agricultural Worker: None Employed Year Round Seasonal Migrant Retired

EMERGENCY CONTACT INFORMATION

First Name: ______________________________ MI: _____ Last Name: ________________________________

Mailing Address: ___________________________ City: ___________________ State: ___ Zip code: __________

Home phone: (___) _____-_________ Work Phone: (___) _____-_________ Mobile Phone: (___) ____-_________

Relationship: _______________________________ May we speak to this person about your health? ____ Yes ____ No

PARENT/LEGAL GUARDIAN (if under 18 years of age):

Name: ____________________________________ Relationship: ____________________ Phone: __________________

"CARING FOR OHANA, CARING FOR YOU"

PAST MEDICAL HISTORY

Date: ________________________
Please help us by answering as many of the following questions as possible. This will help your Provider give you the best medical care.

PLEASE PRINT:
Name: ____ Date of Birth: _________________________
Previous Provider(s): _____________________________________ Reason for changing Provider: ___________________
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Ethnicity: ____ Number of persons living in your home: _________________
Occupation: [ ] Student [ ] Employed [ ] Unemployed [ ] Retired

REASON FOR VISIT:
Why did you come to the doctor today?
____
What other health problems have you had in the last years?
____
Who was your Provider for these problems?
____

Check problems you have had now or had in the past.

Allergies:	Yes [ ]	No [ ] → If yes, what are you allergic to? ____________________
Head:	Yes [ ]	No [ ]
Eyes/Ears:	Yes [ ]	No [ ]
Nose/Mouth/Throat:	Yes [ ]	No [ ]
Thyroid/Other Glands:	Yes [ ]	No [ ]
Chest/Lungs:	Yes [ ]	No [ ]
Heart/Circulation:	Yes [ ]	No [ ]
Stomach/Digestion:	Yes [ ]	No [ ]
Abdomen/Bowel:	Yes [ ]	No [ ]
Kidney/Bladder:	Yes [ ]	No [ ]
Sexual/Reproductive Organs:	Yes [ ]	No [ ]
Skin/Hair/Nails:	Yes [ ]	No [ ]
Bones/Joints/Muscles:	Yes [ ]	No [ ]
Persistent Pain:	Yes [ ]	No [ ]
High Blood Pressure:	Yes [ ]	No [ ]
High Cholesterol:	Yes [ ]	No [ ]
Diabetes:	Yes [ ]	No [ ]
Asthma:	Yes [ ]	No [ ]
Emotional:	Yes [ ]	No [ ]

Other: ____

Do you smoke tobacco?	Yes [ ]	No [ ]	→ How Often? ____________
Do you drink alcohol?	Yes [ ]	No [ ]	→ How Often? ____________
Do you use street drugs?	Yes [ ]	No [ ]	→ How Often? ____________

Would you like to speak to the doctor about:

Financial Problems:	Yes [ ]	No [ ]
Marital Problems:	Yes [ ]	No [ ]
Depression:	Yes [ ]	No [ ]
Alcohol:	Yes [ ]	No [ ]
Drugs:	Yes [ ]	No [ ]
Smoking:	Yes [ ]	No [ ]
Birth Control:	Yes [ ]	No [ ]
Sexual Concerns:	Yes [ ]	No [ ]
Family Anger/violence	Yes [ ]	No [ ]
Living will / Advanced Directive:	Yes [ ]	No [ ]

Other: _____________________________________

Reviewed by: ____ Date: _________________________

"CARING FOR OHANA, CARING FOR YOU"

MEDICATION	DOSE	MEDICATION	DOSE

HOSPITALIZATION/SURGERIES

YEAR	SURGERY/ILLNESS	HOSPITAL/DOCTOR

FAMILY HISTORY

PROBLEM	YES	NO	TYPE OF PROBLEM	WHICH FAMILY MEMBER
Cancer				
Tuberculosis				
Asthma				
Diabetes				
Thyroid				
High Blood Pressure				
Birth Defects				
Mental Disorder				
Alcohol/Drug Abuse				
Heart Disease				
Other				

WOMEN ONLY

Age menstrual period began: ______ Date of last menstrual period: __________ Days of heavy flow: ______________
How often do periods occur? _____________ Do you ever skip periods? _________ Are your period painful? _______
Do you perform Self Breast Exams? __________

Date/Results of Last Mammogram: _______________ Pregnancies: ______ Deliveries: _____Terminations: _____

BIRTH CONTROL METHOD	YEARS USED	PROBLEM/REASON DISCONTINUED