Families First

support for families...health care for all

PATIENT INTAKE FORM - PLEASE PRINT CLEARLY

Please PRINT patient's name clearly: _____

How did you hear about Families First? Please circle the one that most applies: WERZ-107.1 WHEB-103.1

FF Family Center Staff FF Health Center Staff Flyer/Brochure/Poster Friend/Relative Hospital Internet

Insurance Directory/Phone Book Medical/Other Professional Newspaper/Radio/TV Other School

Social Service Agency Please provide details (e.g. paper, other, etc.) _____

Does the patient have health or dental insurance?

- ❒ No, and patient is an adult. (Please ask for an application to see if you are eligible for the **Sliding Fee Scale Discount.)**
- ❒ No, and patient is a child. (Parent/Guardian: Please ask for NH Healthy Kids assistance.)
- ❒ Yes, medical. (Please fill in the information in the box below.)
- ❒ Yes, dental. (Please fill in the information in the box below.)

PLEASE PROVIDE ANY CARD(S) SO WE MAY MAKE A COPY. THANK YOU.

❒ **Primary Health Insurance (Please complete ALL lines below)**

Insurance Co. _____ Subscriber Name: _____

Certificate #: _____ Subscriber SSN: _____

Group #: _____ Subscriber DOB: _____

Effective Dates: _____ Relation to Patient: _____

❒ **Secondary Health Insurance**

Insurance Co. _____ Certificate #: _____ Group #: _____ Effective Dates: _____

If you have insurance, who is listed as your primary care physician (**PCP**)? _____

❒ **SeaCare #:** _____

❒ **Medicare #:** _____

If you have Medicare coverage, a payment authorization must be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked. Please complete and sign the gray box located at the bottom of the signature page.

❒ **Medicaid/Healthy Kids #:** _____

❒ **Dental Insurance (Please complete ALL lines below)**

Insurance Co. _____ Subscriber Name: _____

Certificate #: _____ Subscriber SSN: _____

Group #: _____ Subscriber DOB: _____

Effective Dates: _____ Relation to Patient: _____

Contact your insurance company to ensure that your services will be covered. Some insurance companies will pay only if you go to an "in network" provider. While Families First will bill all insurance companies, we are not in network with all. You will be responsible for any bills not covered by insurance.

Please complete both sides

PATIENT INTAKE FORM - PLEASE PRINT CLEARLY

Full **Legal** Name: _____ Maiden or Other Name / Alias: _____
First Middle Initial Last

Street: _____ PO Box: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Date of Birth: Month _____ Day _____ Year _____

Marital Status: ❒Single ❒Married ❒Other **Gender:** ❒Female ❒Male

If the patient is a child, please fill in the names below:

❒ Mother's Name: _____ ❒Father's Name: _____

❒Legal Guardian: _____
(*** Must show legal documentation)

Please list any person, along with their phone number, that we can discuss your medical issues with this year:

_____ Please initial: _____

AUTHORIZATION AND CONSENT FOR TREATMENT OF A CHILD (If the patient is a child, you must complete below.)

I, _____, born on _____/_____/_____, hereby give permission for Families First Health
Parent/Legal Guardian (*please print)*

Center staff to examine: _____, born on ____/_____/_____, and conduct tests and procedures
Child's Name

as needed for diagnosis and care, and to give such treatment as the health center's providers deem necessary.

_____ _____ _____
Signature of Parent/Legal Guardian Date Relationship to Child

I give permission for Families First to share my child's immunization information with his/her school**.** Please initial: _____

Some of the organizations that give us funding for our programs require us to report on the average income levels and the race/ethnicity of the people we serve. **Your income and race/ethnicity information will not be shared in connection with your name—it will only be shared in the form of summaries about the people we serve.** Thank you.

Is your primary language English? ❒YES ❒NO it is: _____ Do you need an interpreter? ❒NO ❒YES

RACE ❒White/Caucasian ❒Black/African American ❒ Asian
❒Hawaiian ❒Other Pacific Islander ❒American Indian/Alaskan Native

ARE YOU HISPANIC? ❒NO ❒YES **ARE YOU A VETERAN?** ❒NO ❒YES

Are you deaf? ❒NO ❒YES Do you need a sign language interpreter? ❒NO ❒YES

Are you a ❒ Migrant or ❒ Seasonal farm worker?

Total # of household members, including patient: _____

Estimate of total household income: $_____ per ❒ Week ❒ Month ❒ Year

Living arrangements: ❒ Rent ❒ Own ❒ Stay with relatives/friend ❒ Shelter ❒Other temporary housing:_____

I have read and understand the following documents: Notice of Information Practices, No Show/Late Policy, Agency/Patient Contract and Consent to Use and Disclose Health Information. They are all located in Part III of the New Patient Handbook and are also available as handouts. I acknowledge that I have read and understand these documents.

_____ _____
Signature **Date**

Please PRINT the patient's name clearly: _____

PLEASE READ CAREFULLY!

SIGNATURES ARE REQUIRED BELOW BEFORE YOU MAY BECOME A PATIENT.

WE WILL ASK FOR YOUR SIGNATURE EVERY TWELVE MONTHS.

The Foundation for Seacoast Health
Community Campus
Safe Campus Restrictions

In order to keep children and others on the community campus safe, our landlord, (The Foundation for Seacoast Health) will not allow on the Campus people who fall into the following categories.

People who have been determined to be a sexual offender as defined by RSA 651-B,
People who have been determined to be an offender against children as defined by RSA 651-B,
Individuals who may pose a risk to the safety of others.

The Foundation for Seacoast Health is requiring that Families First take steps to make sure that people who fall into the above three categories are not coming to the Community Campus.

By signing this form, I agree to the following:

If Families First determines in its own judgment that I fall into any of the three categories listed above,
I will be immediately discharged from Families First, and will not receive any more services;
I will immediately leave the Community Campus and will not return;
Families First will immediately release my name and address to the Foundation for Seacoast Health; and
I will hold neither Families First nor the Foundations for Seacoast Health responsible for the release of my name and address to the Foundation for Seacoast Health.

The Foundation for Seacoast Health may prohibit me from coming to the Community Campus if it is determined that I fall into any of the three categories listed above.

_____ _____

Signature **Date**

I hereby give permission for Families First Health Center to examine and conduct such referrals, tests and procedures as are needed for my diagnosis and care, and to give such treatment as the health center's providers deem necessary. I understand that Families First, medical and support staff, may disclose and use this information for treatment, including sharing this information with other providers to provide continuity of care.

I hereby authorize release of PHI (Personal Health Information) necessary to file a claim and audit with my insurance company and assign benefits to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier, including, but not limited to, deductible and co-payments. At the end of sixty days, billing is my responsibility. A copy of this signature is valid as the original. The information I have provided is accurate and complete to the best of my ability.

_____ _____

Signature **Date**

If you have MEDICARE coverage you must sign below.

I request that payment of authorized Medicare benefits be made to Families First of the Greater Seacoast for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked.)

Print Name of Beneficiary: _____ Medicare # _____

Signature of Beneficiary or Representative: _____ Date: _____