

# PATIENT INTAKE FORM

PLEASE PRINT CLEARLY

## Lamprey Health Care

Where excellence and caring go hand in hand

If needed, please ask for assistance in completing this form.

Patient Name: \_\_\_\_\_

Have you ever used a different name or names? If yes, please provide: \_\_\_\_\_

Street: \_\_\_\_\_ PO Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_  Work  Cell  Pager  \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status:  Single  Married  Other

Gender/Sex:  F  M Employed:  Full-time  Part-time  Unemployed  Disabled  Retired Date: \_\_\_\_\_

If employed: Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

If the patient is a child, are you the parent or legal guardian?:

Parent  Guardian Your Name: \_\_\_\_\_

Do you have health insurance?

YES Please provide any card(s) so we may make a copy. THANK YOU. If insured is NOT the patient fill in below:

DOB: \_\_\_\_\_ Relation to patient: \_\_\_\_\_

NO To apply for **Financial Assistance**, please fill out green financial assistance application form.

Do you have a preference for a medical provider in this office? Name: \_\_\_\_\_

If you have insurance, who is listed as your primary care physician (PCP) : \_\_\_\_\_

*Optional: Some of our grants require us to report on race and ethnicity of the people we serve. Thank you for your cooperation.*

Are you:  Hispanic  
 Not Hispanic

Race: please check all that apply if more than 1 race

- Multi-Racial  
 Native Hawaiian  White  
 Other Pacific Islander  Asian  
 Black/African American  
 American Indian/Alaskan Native

Are you a student?  Full Time  Part Time

HOW DID YOU HEAR ABOUT US?

Please check how you heard about Lamprey Health Care—this helps us identify better ways to reach our patients, thank you!

- Radio  Newspaper  Website  
 Employee  Friend  Relative  Hospital  
 Walk in  Phone book  School  Health Fair  
 City/State Welfare  Social Service Agency  
 Other provider  Insurance Directory  
 Other: \_\_\_\_\_

Is it okay if we use email to communicate with you?:

I authorize Lamprey Health Care to communicate with me using email.

Email Address: \_\_\_\_\_

IN CASE OF EMERGENCY:

Contact: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Is your primary language English?  YES  NO

If no, what is it? \_\_\_\_\_

Do you need an interpreter?  YES  NO

Are you deaf?  YES  NO

Do you need a sign language interpreter?  YES  NO

**NOTE:** Lamprey Health Care receives state and federal funding to support our services. Occasionally we are asked to report on the general financial status of our patients. We would appreciate it if you would be willing to let us know your approximate household income.

Total # of Adults (18 and older): \_\_\_\_\_

Total # of Children: \_\_\_\_\_

Estimate of total household income: \$ \_\_\_\_\_  
per  Week  Month  Year

Are you a:  Migrant worker or  Seasonal farm worker?

Living arrangements:

- Rent  Own a home  
 Live with relatives/friend  Shelter  Street  
 Transitional  Other: \_\_\_\_\_

PLEASE COMPLETE AND SIGN THE OTHER SIDE

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**Please complete this box if you have Medicare Insurance coverage.**

Name of Beneficiary: \_\_\_\_\_ Medicare#: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made to Lamprey Health Care 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 Lamprey Health Care provides to the beneficiary during his/her lifetime, unless revoked.)

Signature of Beneficiary or Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND CONSENT FOR TREATMENT OF A CHILD**

I, \_\_\_\_\_ have legal custody and hereby give permission for Lamprey Health Care Parent/ Legal Guardian (*please print*) staff to examine: \_\_\_\_\_, born on \_\_/\_\_/\_\_, and conduct tests and procedures 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

**PATIENT COMMUNICATION**

In the event that Lamprey Health Care needs to contact you, please indicate your preferred method.

**By telephone:** \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell)

May we leave a message on your home phone? **YES NO** May we leave a message on your cell? **YES NO**

**By Text:** \_\_\_\_\_ (cell)

**By email:** \_\_\_\_\_

**By letter:** \_\_\_\_\_ (address)

**Please don't contact me using any of the above. Please contact me by:**

**PLEASE READ CAREFULLY!**

I hereby give permission for Lamprey Health Care to examine and conduct such 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 also authorize Lamprey Health Care to release medical information, upon referral to a specialist, for my continued 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.

I understand that income, demographic and non-identifiable clinical information may be shared to receive State, Federal, Private and Research Grants. Identifiable data may be sent as required by law. I have been provided a copy of the Patient Rights & Responsibilities and the HIPAA Notice of Information Privacy Practices. I acknowledge receipt and understanding of these documents.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**FOR OFFICE USE ONLY: INTERPRETER'S STATEMENT** (if applicable) I have translated the information on this form orally to the individual in \_\_\_\_\_ language and explained its contents to her/him. To the best of my knowledge and belief she/he understood this explanation.

\_\_\_\_\_  
Signature of Interpreter

\_\_\_\_\_  
Date