

Lamprey Health Care
Title X Program

Date: _____

TEEN CLINIC PATIENT INTAKE FORM

(PLEASE PRINT CLEARLY)

Patient Name: _____

Have you ever used a different name? If yes what _____

Street: _____ P.O. Box _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: Single married

Home Phone _____ Cell Phone _____ Work Phone _____

Best phone number to reach you for test results, etc.: _____

When is the best time to contact you ? _____

ARE YOUR PARENTS/GUARDIAN AWARE YOU USE TEEN CLINIC SERVICES? Y N

E-mail address : _____

Gender: M F Student: Full Time Part Time

Do you have health insurance Yes No IF YES, CAN WE SUBMIT A BILL TO YOUR INSURANCE COMPANY FOR THIS VISIT? _____.

Do you have a primary care physician? If yes who: _____

Race : WHITE HISPANIC PORTUGESE ASIAN AMERICAN INDIAN
 BLACK /AFRICAN AMERICAN OTHER

How did you hear about us? FRIEND CITY WELFARE SCHOOL HOSPITAL
 WALK -IN MEDIA RELATIVE PHONE BOOK OTHER

IN CASE OF EMERGENCY (PARENT OR GUARDIAN)

CONTACT NAME: _____ RELATIONSHIP: _____
PHONE #: _____

FOR OFFICE USE ONLY

PHONE Y N ABBY Y N

MAIL Y N PLAIN Y N

NO INFO HOME/CONFIDENTIAL Y N

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 requested and 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

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FOR OFFICE USE ONLY

Interpreter's statement: 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