|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PRIMARY CARE PHYSICIAN (PCP): TODAY’S DATE:** | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal last name**: **First**: | | | | | | | | | | | | **Middle**: | | | | | | | **Marital status**: ❑ Single ❑ Married ❑ Divorced  ❑ Separated ❑ Widowed | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Preferred name (if different):** | | | | | **Previous legal name(s):** | | | | | | | | | | **Sex (at birth)**:  ❑ Female ❑ Male | | | | | | **Gender identity**: ❑ Female/woman  ❑ Male/man ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Mailing address: City:**   **State: Zip code:** | | | | | | | | | | | | | | | | | **Date of birth:**  / / | | | | | | **Social Security number:**  – – |
| **Physical address (if different from mailing)**: **City:** **State**: **Zip code:** | | | | | | | | | | | | | | | | | **Where do you live?** ❑ Own home ❑ Rent ❑ Homeless  ❑ Farm Housing ❑ Assisted living ❑ Other | | | | | | |
| **Home phone**:  Okay to leave voicemail? ❑ Yes ❑ No  If yes, what type of voicemail? ❑ Short ❑ Extended | | | | | | **Cell phone**:  Okay to send text? ❑ Yes ❑ No  Okay to leave voicemail? ❑ Yes ❑ No  If yes, what type of voicemail? ❑ Short ❑ Extended | | | | | | | | | | | **Work phone**: **Extension:** | | | | | | |
| **Email address (for patients 18 years and older):** | | | | | | |
| **Preferred method of contact:** ❑ Home ❑ Cell ❑ Work ❑ Text | | | | | | | | | | | **Best time to call:** ❑ Morning ❑ Afternoon ❑ Evening | | | | | | | | | | | | |
| **Student Status:**  ❑ Full-time ❑ Part-time ❑ None | | **Employment status**:  ❑ Full-time ❑ Part-time ❑ None | | | | | | | | | | | | **Employer name (if applicable):** | | | | | | | | | |
| **Emergency contact name:** | | | | | | | **Relationship to patient:** | | | | | | | | | | | **Emergency contact phone:** | | | | | |
| **INSURANCE** | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary insurance carrier:** | | | | | | | | | | | | | | | | **Primary insurance subscriber ID number:** | | | | | | | |
| **Primary insurance subscriber’s name:** | | | | | | | **Primary insurance subscriber’s date of birth:** | | | | | | | | | | | **Primary insurance subscriber’s relationship to patient:** | | | | | |
| **Secondary insurance carrier:** | | | | | | | | | | | | | | | | **Secondary insurance subscriber ID number:** | | | | | | | |
| **Secondary insurance subscriber’s name:** | | | | | | | **Secondary insurance subscriber’s date of birth:** | | | | | | | | | | | **Secondary insurance subscriber’s relationship to patient:** | | | | | |
| **Do you need help applying for insurance?** ❑ Yes ❑ No | | | | | | | | | | **Would you like more information about OOH’s sliding fee program?** ❑ Yes ❑ No | | | | | | | | | | | | | |
| **GUARANTOR** | | | | | | | | | | | | | | | | | | | | | | | |
| **Person responsible for bill (guarantor):** | | | **Guarantor’s date of birth:**  / / | | | | | | | **Address (if different from patient’s):** | | | | | | | | | | | | **Guarantor’s phone number:** | |
| **Is this person a patient at Oak Orchard Health?** ❑ Yes ❑ No | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s relationship to guarantor:** ❑ Self ❑ Spouse ❑ Parent ❑ Step-parent ❑ Child ❑ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
| **HOUSEHOLD INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **Please list all the members of your household:**  **Name: Date of birth: Relationship: OOH patient?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Yes ❑ No | | | | | | | | | | | | | | | | | | | | | | | |
| **DEMOGRAPHIC INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **Ethnicity:** ❑ Hispanic or Latino  ❑ Non-Hispanic or Latino | | **Race (please choose one option):** ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African-American ❑ Native Hawaiian  ❑ Other Pacific Islander ❑ White ❑ Refuse to report | | | | | | | | | | | | | | | | | | | | | |
| **Do you feel comfortable speaking and understanding English in your appointments?**  ❑ Yes ❑ No | | | | **If you do not feel comfortable speaking and understanding English in your appointments, which languages would you feel comfortable using?** | | | | | | | | | | | | | | | | | | | |
| **REQUIRED PEDIATRIC PATIENT INFORMATION (FOR PATIENTS UNDER 19 YEARS OLD)** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of parent/guardian #1:** | | | | | | | | **Address of parent/guardian #1:** | | | | | | | | | | | | | | | |
| **Name of parent/guardian #2:** | | | | | | | | **Address of parent/guardian #2:** | | | | | | | | | | | | | | | |
| **Biological mother’s name (first/maiden):**  This information is used for immunization registry report for NYS | | | | | | | | | | | | | | | | | | | | | | | |
| **SHARED CONSENT** | | | | | | | | | | | | | | | | | | | | | | | |
| **With whom may we share your information?**  **Name: Phone number: Date of birth: Relationship: Health info Account info**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑❑  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑❑  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑❑ | | | | | | | | | | | | | | | | | | | | | | | |
| **PROVIDER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **Please provide the name and location of all your health care providers:**  **Primary pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Optometrist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **OB-GYN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | |
| **REQUIRED INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **FEDERAL GRANT REQUIREMENTS REQUIRE THAT WE COLLECT THE FOLLOWING INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **Where do you receive the majority of your medical care?**  State: Country: | | | | | | | | | **How many people reside in your household?** | | | | | | | | | | | | **What is the *approximate annual total income* of your household?** | | |
| **Are you a veteran?** ❑ Yes ❑ No | | | | | | | | |
| **Occupation related to agriculture** | | | | | | | | | | | | | | | | | | | | | | | |
| 1. In the past two (2) years, have you or a member of your family ever worked in agriculture (farming) as your primary source of employment?   ❑ Yes – Please answer the rest of the questions.  ❑ No – Please skip ahead to D.  *Examples of agricultural work include the following:*   * *Preparing, irrigating, or spraying fields, nurseries, or orchards* * *Planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, plants, tobacco, hops, flowers, grass, hay, alfalfa, or other products* * *Planting trees, working with Christmas trees, or picking pine needles or Spanish moss* * *Taking care of livestock* | | | | | | | | | | | | | 1. In the past two (2) years, have you or a member of your family moved to another area in order to work in agriculture?   ❑ Yes  ❑ No   1. In the past two (2) years, have you or a member of your family worked in agriculture seasonally without needing to move away from your home?   ❑ Yes  ❑ No   1. Has disability or age prevented you or a family member from traveling in order to work in agriculture?   ❑ Yes  ❑ No | | | | | | | | | | |
| **Patient (or patient’s representative) signature:** | | | | | | | | | | | | | | | | | | | **Date:** | | | |
| **ADDITIONAL QUESTIONS** | | | | | | | | | | | | | | | | | | | | | | | |
| **Please take a moment to share the following information. Your input and time is greatly appreciated.**  **How did you hear about Oak Orchard Health?**  ❑ Friend/Relative ❑ Health provider referral ❑ Insurance company ❑ Hospital ❑ Community event (please share the name of the event):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Web ❑ Health fair (please share the name of the fair):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ County fair (please share the name of the fair):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ Advertising (please check the corresponding box):  ❑ Batavia Daily News  ❑ Lake Country Penny Saver/Orleans Hub  ❑ Hornell Spectator  ❑ Suburban News  ❑ Wyoming Country Courier/Warsaw Penny Saver  ❑ Genesee Valley Penny Saver  ❑ Other (please share):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |

Did you know we have a patient portal? Ask us about our patient portal today!

**Patient or patient representative signature: Date:**