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| --- |
| **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 ❑ NoIf yes, what type of voicemail? ❑ Short ❑ Extended | **Cell phone**:Okay to send text? ❑ Yes ❑ NoOkay to leave voicemail? ❑ Yes ❑ NoIf 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❑ No1. 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❑ No1. 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:**