NEW Health

## PATIENT QUESTIONNAIRE

Patient's name: _____ Home#: _____
Last First Middle

Birth Gender: M ☐ F ☐ Date of Birth: _____ SSN#: _____ Cell#: _____

Primary Language: _____ Do you require an interpreter? Yes ☐ No ☐ Work#: _____

Physical Address: _____
Address City State Zip code

Mailing Address if different: _____
Address City State Zip code

Preferred Notification Method: Postal ☐ Phone ☐ Email ☐ Email Address: _____

Place of work: _____ How did you hear about us: _____

Preferred Provider: _____ Preferred Pharmacy: _____

Parent/Guardian's Name: _____ Date of Birth: _____
Last First Middle

## PATIENT INFORMATION

**(Please mark one box in each column)**

| MARITAL STATUS | EMPLOYMENT | STUDENT | SLIDING DISCOUNT |
|---|---|---|---|
| ☐ Single | ☐ Full-Time | ☐ Full-Time | Annual Household Income |
| ☐ Married | ☐ Part-Time | ☐ Part-Time | Number of people in household: _____ |
| ☐ Separated | ☐ Unemployed | ☐ Not Attending | ☐ $0-10,000 ☐ $10,001-15,000 |
| ☐ Divorced | ☐ Self-Employed | ☐ Not Applicable | ☐ $15,001-20,000 ☐ $20,001-30,000 |
| ☐ Widowed | ☐ Retired | | ☐ $30,001-40,000 ☐ $40,001-50,000 |
| ☐ Domestic | ☐ Not Applicable | | ☐ $50,001-60,000 ☐ $60,001 & Over |
| | | | Estimate Income: $ _____ |

**(Please mark one box in each column)**

| RACE | ETHNICITY | GENDER IDENTITY | SEXUAL ORIENTATION | PLEASE MARK ALL THAT APPLY |
|---|---|---|---|---|
| ☐ White | ☐ Hispanic | ☐ Male | ☐ Heterosexual/Straight | ☐ Veteran |
| ☐ Asian | ☐ Non-Hispanic | ☐ Female | ☐ Gay / Lesbian | ☐ Migrant Worker |
| ☐ Black / African-American | | ☐ Transgender male | ☐ Bisexual | ☐ Seasonal |
| ☐ Native Hawaiian | | ☐ Transgender female | ☐ Something Else | ☐ Homeless |
| ☐ Alaskan Native-American Indian | | ☐ Other | ☐ Do not know | |
| ☐ More than One Race | | ☐ Choose not to disclose | ☐ Choose not to disclose | |

## INSURANCE INFORMATION

Primary Insurance_____ ID#_____ Group#_____
Subscriber's Name_____ Date of Birth: _____ SSN#: _____

Secondary Insurance_____ ID#_____ Group #_____
Subscriber's Name_____ Date of Birth: _____ SSN#_____

## EMERGENCY CONTACT

**Please give us an emergency contact that has a different phone number from yours**

Name_____ Male ☐ Female ☐

Relationship to Patient_____ DOB_____ Telephone Number_____

May we leave a message for you with this individual? Yes ☐ No ☐

## AUTHORIZATION FOR TREATMENT AND FINANCIAL DISCLOSURE

I request that payment of Authorized Medicare and/or insurer benefits be made either to me or on my behalf to **NEW Health**. I authorize the holder of medical information about me to release to the Health Care Financial Administration, and its agents, any information needed to determine the benefits or the benefits payable to related services.

**Signature** _____ **Date**_____

# Consents

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

____ I have been offered the 5-page Notice of Privacy Practices document and **have read the material**.

____ I have read the 5-page Notice of Privacy Practices document before and **choose not to read it at this time**. I know that I may ask for a copy to read at any time.

*This includes for treatment: NEW Health may use medical information about you to provide you with medical treatment or services. This may include electronic access of your medication history information. This information could include insurance benefits, eligibility and formulary information, prescribing provider and pharmacy, medication history, as well as prescription refill and renewal information. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care providers who are involved in taking care of you now or in the future.

_____
**Initials**

## PERMISSION TO RELEASE INFORMATION

____ I **authorize** NEW Health to mail or leave detailed messages regarding appointments, lab results or follow-up information to individuals answering my home phone number and/or my answering machine or voice mail system.

____ I **authorize** NEW Health to mail or leave detailed messages regarding appointments, lab results or follow-up information at the following **alternate phone number or mailing address.**

Alternate phone:_____

Alternate address: _____

_____
**Initials**

Please list the names and relationship of **persons authorized by you to receive your health information** verbally, pick up prescriptions on your behalf or pick up medical record information.

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |

****The patient assumes responsibility for updating information as changes occur.**

_____
**Initials**

## CONSENT FOR PHOTOGRAPH

____ I **consent and authorize** NEW Health to photograph me to assist in patient identification or copy my picture identification for healthcare purposes only.

_____
**Initials**

**Patient Name (Printed):** _____

**Patient/Guardian Signature:** _____

**Witness:** _____ **Date:** _____