Intake Information Sheet

inner city HEALTH CENTER

PATIENT INFORMATION

Today's Date_____/_____/_____
MM DD YR

Name _____ _____
First Middle

_____ _____
Last Other Last name used

Address _____
Street Address and Apt. #

_____
City State Zip Phone

Date of Birth _____/_____/_____ Social Security # _____ Sex___F_M
MM DD YR

Married_____Single_____Widowed_____Separated_____Divorced_____Common Law_____

EMPLOYMENT/SCHOOL INFORMATION

SELF
Name of Employer/School_____Work Phone# _____

Address_____City_____State___Zip_____

SPOUSE
Name of Employer/School_____Work Phone#_____

Address_____City_____State___Zip_____

PATIENT'S FAMILY MEMBERS (Please list spouse, parents, children & other close relatives at home)

First Name, Middle Name, Last Name, Last Name of Mother (Maiden)	D.O.B.	Relationship	Social Security	Other Names Used

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MONTHLY HOUSEHOLD INCOME

Total Monthly Income $_____ Source of Income _____

ETHNICITY Please check one

__ Asian

___ African American

___ Caucasian

___ Hispanic

___ Native American

Other _____

___ I do not want to answer this question

How did you hear about this health clinic?_____

What language do you speak? _____ What language do you prefer? _____

Can we call your home to remind you of appointments? ___ Yes ___No

Do you have Medical insurance? Medicaid Medicare Commercial Other
Name/Address_____

Occupation:_____ Church/Religion:_____

Education:_____ Years High School_____ Years College _____

RESPONSIBILITIES AND RELEASES

I understand that by receiving services from the Provider for my family, or myself I am accepting responsibility for payment of charges. Co-Payment is due before treatment is rendered regardless of insurance coverage. I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of insurance benefits to Inner City Health Center directly

I authorize providers at Inner City Health Center to perform all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk.

By signing this document, I verify that the above information is correct and that I agree to notify Inner City Health Center when my financial status changes.

Signature_____ Date_____

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Date:_____

Name_____Age_____ Single Married Divorced Widow(er)

Occupation:_____ Church/Religion:_____

Education:_____ Years High School_____ Years College _____

Date of last complete physical: _____

Please list major symptoms (if any):

FAMILY HISTORY please circle

Has any blood relative ever had:

Cancer	no	yes
Tuberculosis	no	yes
Diabetes	no	yes
Heart trouble	no	yes
High Blood pressure	no	yes
Stroke	no	yes
Epilepsy	no	yes
Mental illness	no	yes
Suicide	no	yes

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

WOMEN ONLY:

Menstrual History

Age at onset_____		
Regular	no	yes
Cycle _____days (from start to start)		
Usual duration _____ days		
Pains or cramps	no	yes
Date of last period _____		

Pregnancy

How many pregnancies? _____		
How many children born alive?_____		
How many miscarriages? _____		
How many voluntary abortions? _____		
How many premature? _____		
How many Caesarian sections? _____		
Any complications with any pregnancy?	no	yes

HAVE YOU EVER HAD
(please circle answers)

Chest pain	no	yes
Heart problems	no	yes
Asthma	no	yes
Stomach, intestinal, or colon problems (ulcers)	no	yes
Diabetes	no	yes
Recent weight gain or loss	no	yes
High blood pressure	no	yes

Surgery:		
Appendectomy	no	yes
Other	no	yes
Stayed overnight in a hospital	no	yes
Allergy to any medication	no	yes
Cancer	no	yes
Kidney or urine problems	no	yes
Depression	no	yes
Allergies or hay fever	no	yes

Do you drink alcoholic beverages?	no	yes	drinks per day_____
Do you smoke?	no	yes	packs per day_____
Are you sexually active?	no	yes	number of partners_____
Have you ever had any venereal disease (Sexually transmitted disease)?	no	yes	
Do you take birth control pills?	no	yes	

What medicines do you take? _____

Acknowledge of Receipt of Notice of Privacy Practices

I have received this office's Notice of Privacy Practice, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Patient's Representative

_____

Date

This form is to be place in the Patient's medical file. This form is to be retained for a minimum of six years. Should the Patient choose not to sign this form, please comment below as to why the Patient did not sign and then place this form in the Patient's medical file.

Comments (if Applicable):

Form received by:

_____

Name Date

Inner City Health Center
Appointment Cancellation Policy

MEDICAL DEPARTMENT

PLEASE READ CAREFULLY

Out of respect for all of our patients' needs, we ask that you follow this policy regarding cancellations of appointments. **If a patient does not notify Inner City Health Center at least 24 hours prior to an appointment**, the appointment will be treated like a "No-show" and will be handled as described below:

- **Established Patient** that does not show up for an appointment, the patients' chart will be noted.
- If a **New Patient** does not show up for their first appointment, their information will be deleted from the computer and their paperwork will be shredded.
- If any **Patient** misses his/her appointment and does not call to cancel you will be charged $10.00 each time you "***No-show***" for a 30 minute appointment. You will be responsible for paying this bill *regardless of insurance* before you can schedule another appointment.
- After **Any "No-shows"** per family, no appointments will be given until you **pay your $10.00** fee.
- If you repeatedly miss your scheduled appointments, your Provider may decide to terminate you and your family from our care at Inner City Health center.

Thank you for your cooperation. Please talk to the Front Desk Receptionist if you have questions regarding this policy.

I have read and understand the appointment cancellation policy and I understand my responsibilities to keep my appointments.

Signature: _____ Date: _____

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Date: _____

Emergency Contacts:

Name: _____ Telephone number_____

Name: _____ Telephone number_____

What language/s do you speak: _____

What language do you prefer: _____

Consent to treat a minor:

If parents or legal guardian are unable to bring minor to his/her appointment you may authorize any other person over the age of 18 to bring them. By signing this form I authorize Inner City Health Center to treat and administer medications, vaccines or any other medical procedure my son or daughter may need. The following people have my permission to bring them.

Name_____

Relationship to minor: _____

Name_____

Relationship to minor: _____

Name_____

Relationship to minor: _____

Signature_____Date_____

This form will expire one year from the date of signature