HONOR COMMUNITY HEALTH
PATIENT INTAKE FORM

Thank you for selecting us. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION *(Confidential)*							
Today's Date		Last Name		First		M.I.	
Date of Birth		Social Security No.	- -				
Street Address				Apartment/Unit#			
Mailing Address							
City		State		ZIP Code			
Home Phone		Work Phone		Cell Phone			
Parent or Guardian Name		Relationship?					
May we text you with appointment reminders and information regarding your healthcare? ☐ Yes ☐ No *Standard data fees & text message rates may apply based on your mobile phone carrier.							
Email address for use in HCH Patient Portal ☐ Yes ☐ No Is it OK to e-mail information? ☐ Yes ☐ No		Email					
Gender at Birth	☐ Female ☐ Male	Current Gender	☐ Female ☐ Transgender Male (Female to Male) ☐ Male ☐ Transgender Female (Male to Female) ☐ Other ☐ Choose not to disclose				
Sexual Orientation	☐ Straight/Heterosexual ☐ Something else ☐ Lesbian or Gay ☐ Don't know ☐ Bisexual ☐ Choose not to disclose						
Race *(Please check all that apply)*	☐ American Indian/ Alaska Native ☐ Asian ------- If yes, please check: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Black/ African American ☐ Native Hawaiian/ Other Pacific Islander---- If yes, please check origin: ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ White/ Caucasian ☐ Refuse to report						
Ethnicity	☐ Hispanic/Latino ---- If yes, please check origin: ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other ☐ Not Latino/Hispanic ☐ Refuse to report						
Language you are most comfortable with:	☐ English ☐ Spanish ☐ Other (please specify) ______________________						

Patient Name: ____________________________________ Date of Birth: ______________

Marital Status:	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Please tell us about your living situation: All information is confidential.	☐ I / we own or rent home/ apartment ☐ I / we have been homeless in the last year and have housing now (Transitional) ☐ Staying with friends/relatives because I have no other choice (Doubling Up) ☐ Staying in a shelter (Short term housing like HOPE, SOS, Haven, etc.) ☐ Staying in a treatment facility (Transitional) ☐ Living on the street, outdoors, or in a car/travel trailer/camper (Street) ☐ Living somewhere not meant to be a home – no running water or heat (Other homeless) ☐ Other: _________________________ Have you been homeless at any time in the past 12 months? ☐ Yes ☐ No Date: _____________ Are you worried about losing your housing? ☐ Yes ☐ No
Military Status	☐ Active Duty Military ☐ Retired Military ☐ Veteran
Employment Status	☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ FT Student Student, what school do you attend? __________________ ☐ PT Student
Employer	Occupation
If employed in agriculture:	☐ Migrant ☐ Seasonal ☐ Employed Year Round
Preferred Pharmacy	Pharmacy Name: ___________________________ Pharmacy Address: __________________________ Pharmacy Phone Number: _____________________
Advanced Directive	Do you have an Advanced Directive? ☐ Yes ☐ No If No, would you like more information on this? ☐ Yes ☐ No
Do you receive services from any of the following agencies?	☐ Community Network Services (CNS) ☐ Easter Seals (ES) ☐ Oakland Family Services (OFS) ☐ Common Ground ☐ None ☐ Training and Treatment Innovations (TTI) ☐ Community Living Services (CLS) ☐ Community Housing Network (CHN) ☐ Macomb Oakland Regional Center (MORC)

Please tell us how you heard about Honor Community Health____

Honor Community Health is dedicated to ensuring you have access to our services and our staff is available to assist you in determining if you are eligible for a variety of health benefit coverage options. No one is denied care due to inability to pay. These options may include ability to pay based on sliding fee discounts, special grant-provided services or public-funded health care coverage. In many cases, our staff can assist qualifying patients with the enrollment or assessment process. Honor Community Health offers discounted fees for qualified patients who may be unable to pay the full fee for services. As a non-profit organization, we receive funding from local, state, federal and grant funding sources and we are required to collect financial information from our patients to continue to receive this funding. All information will remain confidential. By declining to provide the requested financial information, you will be ineligible for financial assistance for your care.

Patient Name: ______________________________________ Date of Birth: _______________

What is your total household income? (This is confidential and only reported anonymously)	How many family members live in your household?
☐ 0 - $10,000 ☐ $30,001 - $40,000 ☐ $10,001 - $20,000 ☐ $40,001 - $50,000 ☐ $20,001 - $30,000 ☐ $50,001 or more	_______________________

☐ I chose not to answer the above questions about my household income and individuals in home.

EMERGENCY CONTACT					
Name			Relationship		
Home Phone		Cell Phone		City/State	

CURRENT HEALTHCARE PROVIDER		
Do you have a previous Medical Care Provider?	☐ Yes ☐ No	*If Yes – please list:*
Do you have a Dentist?	☐ Yes ☐ No	*If Yes – please list:*

PRIMARY INSURANCE *(you will be asked to show your card at the appointment)*

Name of Policy Holder ____

Insurance Company Name ____________________________________ Policy Start Date ______________________

Policy/ID Number _______________________________ Group/Plan Number ________________________________

Claims Address ____

City ____ State _____________ Zip ____________________________

SECONDARY INSURANCE – if appropriate *(you will be asked to show your card at the appointment)*

Name of Policy Holder ____

Insurance Company Name ____________________________________ Policy Start Date ______________________

Policy/ID Number _______________________________ Group/Plan Number ________________________________

Claims Address ____

City ____ State _____________ Zip ____________________________

FOR OFFICE USE ONLY	***Date Entered***		***Staff Initials***	

Patient Name: ____________________________________ Date of Birth: ______________

HEALTH HISTORY FORM

Have you ever been hospitalized, other than for surgery?
☐ Yes ☐ No *If Yes, please specify below*

Reason for Hospitalization	Date

Have you been to the emergency room in the last 12 months?
☐ Yes ☐ No *If Yes, please specify below*

Reason for Emergency Room Visit	Date

Past Surgeries	Medical Problems / Conditions / Illness	Date

Please list all doctors you have seen in the last 12 months:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list all medications that you are currently taking including: prescriptions, over the counter, and herbal/holistic medications. Please list dose and amount. *(If you need more space, please use the back of this sheet)*

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Do you have any allergies? (Food, medication or environmental allergies)
☐ Yes ☐ No *If Yes, please specify below*

Allergy	Reaction

Have you or any blood relative had: (Please write who was diagnosed i.e. brother, sister, aunt, uncle, children)

	Myself	Relative (specify)
Diabetes	☐	☐ _______
Blood Clots	☐	☐ _______
High Blood Pressure	☐	☐ _______
Kidney Disease	☐	☐ _______
Heart Disease	☐	☐ _______
Lung Disease	☐	☐ _______
Cancer	☐	☐ _______
Epilepsy	☐	☐ _______
Arthritis	☐	☐ _______
Alcoholism	☐	☐ _______

	Myself	Relative (specify)
Mental Illness	☐	☐ _______
Hepatitis	☐	☐ _______
HIV	☐	☐ _______
Drug Use	☐	☐ _______
Colo-Rectal Cancer	☐	☐ _______
Rectal Polyps	☐	☐ _______
Tuberculosis	☐	☐ _______
Osteoporosis	☐	☐ _______
Other	☐	☐ _______

Patient Name: ____________________________________ Date of Birth: ______________

Please circle (Y) Yes or (N) No:

Question	Answer
Do you drink caffeine drinks?	Y / N
Do you exercise regularly?	Y / N
Do you urinate often?	Y / N
Do you feel you are overweight or underweight?	Y / N
Have you had a physical in the last year?	Y / N
Have you had a flu shot in the last 12 months?	Y / N
Have you ever tested positive for Tuberculosis (TB)?	Y / N
Do you see a dentist at least once a year?	Y / N
Do you have reliable transportation?	Y / N
Do you have any trouble taking or getting your medications?	Y / N
Do you have trouble/difficulty with daily activities?	Y / N
Do you feel safe at home?	Y / N
Have you ever used tobacco?	Y / N
Do you currently use tobacco? If yes, for how long _______ years?	Y / N
Do you use drugs? (Marijuana, cocaine, heroin, etc.)	Y / N
Do you drink alcohol? If yes, how many times per week? _____________	Y / N

FOR WOMEN

Date of last menstrual period: __________________

Date of last Pap smear: _______________________

Question	Answer
Have you ever had an abnormal Pap smear?	Y / N

Date of last mammogram: _____________________

Question	Answer
Have you ever had an abnormal mammogram?	Y / N
Do you check your breasts for lumps monthly?	Y / N
If you are over the age of 50, have you been tested for colon cancer?	Y / N
Was the test abnormal?	Y / N

FOR MEN

Date of last prostate/PSA exam: __________________

Question	Answer
Have you ever had an abnormal prostate exam?	Y / N
If you are over the age of 50, have you been tested for colon cancer?	Y / N
Was the test abnormal?	Y / N

List the countries you have visited in the past year: ____

Is there anything else we should know about your health or past medical history?

____

____

Do you have any concerns?

____

____

This information is confidential. This form is part of the medical record. If you had difficulty completing it or have further comments a staff member can assist you.

Patient Name: ___________________________________ Date of Birth: ______________

I hereby consent to all treatment, including tests, procedures and medications as deemed necessary by the clinician staff of Honor Community Health. I authorize the release of any information necessary for my ongoing care or to process any insurance claims related to my care. I agree to pay any charges at the time of service or upon receipt of statement. I grant permission for third party auditors to view my private health information as part of Honor Community Health's quality improvement and evaluation process.

Patient or Legal Guardian Signature		**Date**	
Patient name (please print)			
Legal Guardian name (please print)			

Please Note The Following With Regard To Treatment

Honor Community Health staff will depend on statements made by the patient, information provided in patient's medical history and other information as available to evaluate a patient's condition and decide on the best treatment.

Some services at Honor Community Health may be provided with telemedicine equipment and involve interaction with providers who are not physically in the clinic for your appointment. These sessions are transmitted via secure, dedicated high-speed lines and are not: videotaped, routed through the Internet, or saved in any way. However, relevant information from your visit will be documented in your medical records, just as it would be if the provider had been physically present.

Your healthcare providers will discuss with you the benefits and risks of treatment. If you are unclear about your treatment or the protection of your records, please feel free to ask questions at any time.

I consent to Honor Community Health providing, and my receipt of, any and all services available through Honor Community Health's telemedicine platform. I understand that I can revoke this consent at any time by informing Honor Community Health in writing.

Signature_________________________________If signing on behalf of someone else, relationship________________

Date ________________

Confidentiality Permission Agreement

I give the person(s) listed below access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below.

Name_________________________________Relationship________________Phone Number______________

Name_________________________________Relationship________________Phone Number______________

I give permission to the individual listed below to bring my children to their health care appointments and pick up medication from the pharmacy.

Name_________________________________Relationship________________Phone Number______________