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Preferred Pharmacy (with address):

_____

_____

New Patient Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

You will notice that we ask questions about race and ethnic group background. We do this so we can provide a more cultural appropriate treatment and make sure everyone gets the highest quality of care.

While this clinic recognizes differences in gender identities, sex and sexual orientation; many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Please print all responses: **Date:** _____

Legal Name:_____**Social Security Number:**_____**DOB:** _____

Preferred Name: _____**Pronoun Used:** _____

Address: _____

Phone Number:_____**Work Number:**_____**Cell Number:** _____
(ok to leave message: **Y N**) (ok to leave message: **Y N**) (ok to leave message: **Y N**)

Email Address: _____
(ok to contact by email: **Y N**)

Sex Assigned At Birth: _____ **Identified Gender:** _____

Gender(s) of Sexual Partners: _____ **Sexual Orientation:** _____

Race: (e.g.: African-American, Latino, Asian, etc): _____

Ethnicity: (e.g.: Mexican, Hawaiian, Irish, etc): _____

Education Level:_____**Occupation:** _____

Number of hours Worked per Week:_____**Religious/Spiritual Beliefs:**_____

Relationship/Marital Status:_____(Partnered, living together, Divorced)

Name of your Partner or Spouse: _____

Do you live with anyone?_____**Number of children**:_____**Ages**: _____

_____

How did you hear about us? Advertisement, Billboard, Google, Word of mouth, Social Media, other_____

Language spoken most often:_____**Do you need an interpreter?** ◯ Yes ◯ No

The confidentiality of your health information is protected in accordance with Federal Protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPPA).

Updated 5/2023

INSURANCE INFORMATION

Primary Insurance Type: _____

ID:_____**Subscriber:** _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary Insurance Type: _____

ID:_____**Subscriber:** _____

Insurance Address: _____

Insurance Phone Number: _____

I have presented evidence of valid insurance coverage, as of this date below to AARC Health Equity Clinic. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time of services are rendered.

I,_____**, hereby assign** all medical provider benefits payable (i.e. Payor: Private Insurance company, Medicare, Medicaid, etc.) and related rights existing under the Payor coverage that I have identified in connection with the services provided directly to the AARC Health Equity Clinic and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS, for payment purposes. I understand that any payment received by the AARC Health Equity Clinic for this period may be applied to any unpaid bill(s) for which I am liable.

I understand that different Payor's have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary. **I understand** that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled. **I understand that AARC is a Payor of last resort and I am responsible for any unpaid charges.**

I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the AARC Health Equity Clinic the full balance that is not reimbursed by my medical provider benefits (certain regulations and exceptions apply for Medicare Beneficiaries).

Additionally, if the AARC Health Equity Clinic elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that the Facility and/or its agents have the authority to pursue any and all appeals, including arbitration on my behalf. This financial responsibility is hereby affirmed and acknowledged by my signature below.

I understand that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts and paid in a timely manner. **I understand that I am obligated to pay all co-payments, deductibles and any non-covered out-of network/reduced benefits at the time services are rendered.** I understand that it is my duty to inquire about financial assistance and/or payment plan options available to me.

_____ _____

Patient Signature **Date**

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MEDICAL AND FAMILY HISTORY

Please check all that apply: (P) for yourself. (F) for Family Member

(P)	(F)	
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Pneumonia
☐	☐	Bronchitis
☐	☐	Asthma
☐	☐	Allergies
☐	☐	Heart Disease
☐	☐	Stroke
☐	☐	High Blood Pressure
☐	☐	Elevated Cholesterol
☐	☐	Diabetes
☐	☐	Venous Thrombosis
☐	☐	Hepatitis A
☐	☐	Hepatitis B

(P)	(F)	
☐	☐	Hepatitis C
☐	☐	Cirrhosis
☐	☐	Anemia
☐	☐	Thyroid Problem
☐	☐	Gallbladder
☐	☐	Ulcers
☐	☐	Frequent Urination
☐	☐	Urinary Tract Infections
☐	☐	Sexually transmitted infections
☐	☐	Prostate Trouble

(P)	(F)	
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Fractures
☐	☐	Migraines
☐	☐	Depression
☐	☐	Anxiety or Panic Disorder
☐	☐	Post-traumatic Stress Disorder
☐	☐	Alcohol Use Problem
☐	☐	Substance Use Problem
☐	☐	Chronic Pain
☐	☐	Other:

_____

OPERATIONS AND HOSPITALIZATIONS:

Please list any surgeries and/or hospitalization reasons and date: _____

_____

_____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATION: (Please include any over-the-counter drugs as well as vitamins, aspirin, etc.)

Medication Name	Dose	Frequency of Use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you need additional room, please list other medications on the back of this page.

Please mark down if you have been feeling any of the following:

Review of Systems:

General:
- Recent weight loss/gain
- Fatigue
- Fever
- Changes in appetite
- Night sweats

Skin:
- Rashes
- Lumps
- Itching
- Dryness
- Color Changes
- Hair and Nail Changes

Head:
- Headaches
- Head injuries
- Dizziness

Eyes:
Date of last exam: _____
- Glasses
- Contacts
- Eye Pain
- Double Vision
- Redness
- Glaucoma
- Cataracts

Nose:
- Frequent colds
- Nasal stuffiness
- Nose bleeds
- Sinus trouble
- Allergies

Ears:
- Hearing Loss
- Ear Pain
- Ringing in the ear

Mouth and Throat:
Date of last dental exam _____
- Bleeding gums
- Frequent sore throat
- Hoarseness

Neck:
- Goiter
- Lumps
- Swollen Glands
- Pain

Respiratory:
- Cough
- Wheezing
- Shortness of breath
- Coughing up blood

Cardiac:
- Heart murmur
- Chest pain
- Palpitations
- Swelling of feet

Gastrointestinal:
- Trouble swallowing
- Heartburn or gas
- Nausea
- Vomiting
- Rectal bleeding
- Constipation
- Diarrhea
- Abdominal Pain
- Hemorrhoids

Urology:
- Frequent urination
- Painful urination
- Blood in urine
- Stones
- Difficulty urinating/holding

Musculoskeletal:
- Joint Stiffness
- Arthritis
- Gout
- Backache
- Muscle pains or cramps

Peripheral Vascular:
- Leg cramps while walking
- Varicose Veins
- Thrombophlebitis

Neurological:
- Fainting
- Blackouts
- Seizures
- Weakness
- Numbness
- Tremors
- Tingling of hands/feet
- Memory Changes

Psychiatric:
- Anxiety
- Depression
- Phobias
- Eating Disorder
- Confusion
- Speech/Memory Disorder

Endocrine:
- Heat or cold intolerance
- Excessive sweating
- Excessive urination
- Excessive hunger
- Anemia
- Easy bruising or bleeding

Other:

Have you ever been hit, slapped and/or kicked or otherwise physically hurt by someone?

YES, in the past year YES, prior to this past year NO

VACCINATIONS/PREVENTION

Date of last Tetanus Vaccination:____/___/____

Have you received any of the following vaccines:

Hepatitis A: ◯Yes ◯No ◯Not sure

Hepatitis B: ◯Yes ◯No ◯Not sure

Pneumovax: ◯Yes ◯No ◯Not sure

Others: _____

Date of last Colonoscopy:_____/_____/_____

Check here if Not Applicable: ☐

Are there any firearms kept in your home? ◯Yes ◯NO

Does someone have a **Power of Attorney or Healthcare Proxy** giving them the power to make decisions about your care in life-threatening situations? ◯Yes ◯No **Name of Person/Relationship:** _____

Do you have an **Advanced Directive** such as **DNR** (Do not resuscitate)? ◯Yes ◯No

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LIFESTYLE & HEALTH HABITS

Do you follow a special diet? ◯Yes ◯No If **YES, please check** all that apply:

◯Vegetarian ◯Low Fat ◯Low Carb ◯High Fiber ◯Calorie Restriction ◯Other

Have you ever hinged, purged or restricted your food intake? ◯No ◯Yes, describe: _____

What concerns do you have about your eating practices? _____

How often do you exercise at a moderate or vigorous level for 30 minutes or more? _____

What type of exercise and/or sports do you engage in? _____

On a typical day, how many cups of caffeine containing beverages do you have?_____(coffee, tea, soda, energy drinks, etc).

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SEXUAL HISTORY

When you have sex, do you have the following: (check all that apply)

◯ Oral Sex ◯ Vaginal Sex ◯ Anal Insertive (Top) ◯ Anal Receptive (Bottom)

How often do you use condoms when having the following:

◯ Always ◯ Sometimes ◯ Never

When was the last time you had sex without using a condom? _____

Do you have a Primary Sexual Partner? ◯ Yes ◯ No **Do you have any Casual Sexual Partners?** ◯ Yes ◯ NO

When was the last time you were tested for HIV?_____ **What were the results:** ◯ Negative ◯ Positive

Have you ever been diagnosed (and when) with any of the following?

◯ Syphilis ◯ Gonorrhea ◯ Pelvic Inflammatory Disease ◯ Herpes ◯ Trichomonas

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

◯ Genital Warts ◯ Yeast Infections ◯ Bacterial Vaginosis ◯ Chlamydia ◯ Crabs

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Do you know or believe that any of your partners have had HIV or another sexually transmitted infection?

◯ Yes ◯ No ◯ Not Sure

Have your current partners been tested for HIV or other sexually transmitted infections? ◯ Yes ◯ No ◯ Not sure

What were their results? ◯ Negative ◯ Positive ◯ Not Sure

Are you satisfied with your sexual life? ◯ Yes ◯ No ◯ Not sure

Has anyone ever forced you into having any type of sexual activity? ◯ Yes ◯ No

GENDER IDENTITY

Please list any questions, concerns or comments you have, if any, about your gender, gender identity (sense of your Femaleness or Maleness) or sexual concerns. _____

_____

SUBSTANCE USE HISTORY

How many drinks containing alcohol do you have, on an average, per week? _____

Have you ever been concerned about drinking? ◯ Yes ◯ No ◯ Not Sure

Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down? ◯ Yes ◯ No ◯ Not Sure

Do you use nicotine/tobacco products? ◯ Yes ◯ Never ◯ Quit

How long ago did you quit? _____

How many cigarettes do you smoke per day? _____ **How old were you when you first started smoking?** _____

Have you tried to quit? ◯ Yes ◯ No ◯ N/A **Are you interested in quitting?** ◯ Yes ◯ No ◯ N/A

Please check any of the substances listed below that you have used, even if it was only once:

◯ Marijuana ◯ Cocaine ◯ Crystal Meth ◯ Heroin ◯ Other Opiates (Oxycodone, Vicodin, etc.)

◯ Ecstasy ◯ Mushrooms ◯ LSD ◯ Other Substances

When was the last time you used it and how often? _____

How did you use it (i.e. Smoke, inject, etc.) _____

Did you ever share your needle, cooker, cotton, rinse or any other part of your set? ◯ Yes ◯ No ◯ Not Sure

What type of problems has drug use cause for you (i.e. relationships with others, problems at work, depression, anxiety, physical health, etc.) _____

_____

_____

_____

What concerns, if any, do you have about either your past or current drug use? _____

_____

_____

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide a more complete and knowledgeable care of you. If you have any questions, please see our clinic staff.

Updated 5/2023