

## **NEW PATIENT REGISTRATION - ADULT**

### **PATIENT INFORMATION**

First Name \_\_\_\_\_ Date \_\_\_\_\_

Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: Male ☐ Female ☐ Social Security # \_\_\_\_\_

Email \_\_\_\_\_ Contact Phone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Contact Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

### **FEES AND BILLING**

No patient will be denied service due to inability to pay. We offer a Sliding Fee Discount program which can provide discount fees for services. To see if you qualify, please complete the information below.

Gross Monthly Household Income \$ \_\_\_\_\_

Number of Family Members in Your Household \_\_\_\_\_

I decline to see if I qualify for Sliding Fee Discount ☐

### **ASSISTANCE**

Does the patient require language interpretation for appointments? ☐ Yes ☐ No

Does the patient require sign language interpretation for appointments? ☐ Yes ☐ No

Does the patient need help with transportation to/from their appointments? ☐ Yes ☐ No

**PLEASE COMPLETE OTHER SIDE**



PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**INSURANCE INFORMATION**

**Do you have health insurance?** Yes ☐ No ☐

If no, would you like information on signing up for health insurance? Yes ☐ No ☐

Insurance Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Subscriber relationship to patient \_\_\_\_\_ Subscriber Social Security# \_\_\_\_\_

*Subscriber's Employer* \_\_\_\_\_

*Employer's Address* \_\_\_\_\_

\_\_\_\_\_

**Do you have a secondary insurance?** Yes ☐ No ☐

Insurance Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

Subscriber relationship to patient \_\_\_\_\_ Subscriber Social Security # \_\_\_\_\_

*Subscriber's Employer* \_\_\_\_\_

*Employer's Address* \_\_\_\_\_

\_\_\_\_\_

## NEW PATIENT HEALTH ASSESSMENT

|                                                 |                       |
|-------------------------------------------------|-----------------------|
| <b><u>Patient Name:</u></b>                     | <b>Date of Birth:</b> |
| <b><u>Preferred Name:</u></b>                   | <b>Sex:</b>           |
| <b>Medical History:</b> _____<br>_____<br>_____ |                       |
| <b>Surgeries:</b> _____<br>_____<br>_____       |                       |
| <b>Allergies:</b>                               |                       |
| <b>Medications:</b> _____<br>_____              |                       |

### Family History:

|                                   |                                         |                                              |                                           |                                          |
|-----------------------------------|-----------------------------------------|----------------------------------------------|-------------------------------------------|------------------------------------------|
| <b>Mother:</b>                    | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Maternal Grandmother:</b>      | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Maternal Grandfather:</b>      | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Father:</b>                    | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Paternal Grandmother:</b>      | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Paternal Grandfather:</b>      | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Sister:</b>                    | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |
| <b>Brother:</b>                   | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Breast Cancer    | <input type="checkbox"/> Prostate Cancer |

**Tobacco/Alcohol/Substance Use:**

|                                                    |                                                                        |                                                        |                                      |                                    |
|----------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------|------------------------------------|
| <b>Smoking:</b>                                    | <input type="checkbox"/> Never                                         | <input type="checkbox"/> Former                        | <input type="checkbox"/> Every Day   | <input type="checkbox"/> Some Days |
| <i>If yes to "Former / Every Day / Some Days":</i> |                                                                        | <input type="checkbox"/> Cigarettes                    | <input type="checkbox"/> Pipe        | <input type="checkbox"/> Cigars    |
| <b>Passive Exposure (Secondhand Smoke):</b>        | <input type="checkbox"/> Never                                         | <input type="checkbox"/> Past                          | <input type="checkbox"/> Current     |                                    |
| <b>Smokeless (Chewing Tobacco):</b>                | <input type="checkbox"/> Never                                         | <input type="checkbox"/> Former                        | <input type="checkbox"/> Current     |                                    |
| <b>Vaping:</b>                                     | <input type="checkbox"/> Current Every Day                             | <input type="checkbox"/> Current Some Days             | <input type="checkbox"/> Former User | <input type="checkbox"/> Never     |
| <b>Alcohol Use:</b>                                | <input type="checkbox"/> Yes<br><input type="checkbox"/> Not Currently | Drinks per day _____<br><input type="checkbox"/> Never | Drinks per week _____                |                                    |
| <b>Substance Use:</b>                              | <input type="checkbox"/> Yes                                           | <input type="checkbox"/> Not Currently                 | <input type="checkbox"/> Never       |                                    |

**Physical Activity:**

|                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------|
| <b>On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?</b> _____ |
|----------------------------------------------------------------------------------------------------------------------|

**Sexual Activity:**

|                                 |                                                                           |                                         |                                |
|---------------------------------|---------------------------------------------------------------------------|-----------------------------------------|--------------------------------|
| <b>Are you sexually active?</b> | <input type="checkbox"/> Yes                                              | <input type="checkbox"/> Not currently  | <input type="checkbox"/> Never |
| <i>If yes:</i>                  | Partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female | Type of birth control/protection: _____ |                                |

**Social Connections:**

|                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>In a typical week, how many times do you talk on the phone with family, friends, or neighbors?</b>                                                                                       |
| <input type="checkbox"/> Never <input type="checkbox"/> Once a week <input type="checkbox"/> Twice a week <input type="checkbox"/> Three times a week <input type="checkbox"/> More than 3x |
| <input type="checkbox"/> Choose not to disclose                                                                                                                                             |
| <b>How often do you get together with friends or relatives?</b>                                                                                                                             |
| <input type="checkbox"/> Never <input type="checkbox"/> Once a week <input type="checkbox"/> Twice a week <input type="checkbox"/> Three times a week <input type="checkbox"/> More than 3x |
| <input type="checkbox"/> Choose not to disclose                                                                                                                                             |
| <b>How often do you attend church or religious services?</b>                                                                                                                                |
| <input type="checkbox"/> Never <input type="checkbox"/> Once a week <input type="checkbox"/> Twice a week <input type="checkbox"/> Three times a week <input type="checkbox"/> More than 3x |
| <input type="checkbox"/> Choose not to disclose                                                                                                                                             |
| <b>Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?</b>                                                           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Choose not to disclose                                                                                    |
| <b>How often do you attend the meetings of the clubs or organizations you belong to?</b>                                                                                                    |
| <input type="checkbox"/> Never <input type="checkbox"/> 1-4 times per year <input type="checkbox"/> More than 4x per year <input type="checkbox"/> Choose not to disclose                   |
| <b>Are you married, widowed, divorced, separated, never married, or living with a partner?</b>                                                                                              |
| <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never married               |
| <input type="checkbox"/> Living with a partner <input type="checkbox"/> Choose not to disclose                                                                                              |
| <b>Do you have any Advanced Care Planning Documents? (i.e., Durable Power of Attorney for Healthcare, Advanced Directive or POLST)?</b>                                                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please ask your provider about these.                                                                                       |

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*For Future Use\*\*\*** Please initial and date below once you have reviewed this form at each annual review.

|       |  |       |  |       |  |       |  |
|-------|--|-------|--|-------|--|-------|--|
| _____ |  | _____ |  | _____ |  | _____ |  |
| _____ |  | _____ |  | _____ |  | _____ |  |

# PATIENT DEMOGRAPHIC QUESTIONNAIRE

\*\*\*Thank you for completing/reviewing this form. Your (voluntary) participation helps us better understand our patients and fulfill our mission as a community health center.\*\*\*

Date:

## GENERAL INFORMATION (Fill out for self/patient)

|                                                  |            |                                                                                                       |                          |
|--------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------|--------------------------|
| Patient Legal First Name:                        | Last Name: | Preferred Name:                                                                                       | Date of Birth (patient): |
| 1a. What is your (patient's) preferred language? |            | 1b. Do you (patient) need an interpreter?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                          |

## HOUSING / INCOME (Fill out based on household information)

|                                                                                                                                                                                    |                                                                                                                                                                |                                              |                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------|
| 2. How many people are in your household, including yourself?                                                                                                                      | 3. What is your annual household income (total combined for you and your household)?<br>Depending on your income, you may be eligible for assistance. \$ _____ |                                              |                                          |
|                                                                                                                                                                                    | <input type="checkbox"/> \$0-15,500                                                                                                                            | <input type="checkbox"/> \$26,001-31,000     | <input type="checkbox"/> \$55,001-64,000 |
|                                                                                                                                                                                    | <input type="checkbox"/> \$15,501-20,000                                                                                                                       | <input type="checkbox"/> \$31,001-39,000     | <input type="checkbox"/> \$64,001-85,000 |
|                                                                                                                                                                                    | <input type="checkbox"/> \$20,001-26,000                                                                                                                       | <input type="checkbox"/> \$39,001-55,000     | <input type="checkbox"/> \$85,001+       |
| 4. What is your housing situation today? I have steady housing: <input type="checkbox"/> Own <input type="checkbox"/> Rent                                                         |                                                                                                                                                                |                                              |                                          |
| I do not have steady housing:                                                                                                                                                      |                                                                                                                                                                |                                              |                                          |
| <input type="checkbox"/> Doubling Up (Couch Surfing)                                                                                                                               | <input type="checkbox"/> Homeless Shelter                                                                                                                      | <input type="checkbox"/> Street / Park / Car |                                          |
| <input type="checkbox"/> Permanent Supportive Housing                                                                                                                              | <input type="checkbox"/> Transitional (Recovery Home)                                                                                                          | <input type="checkbox"/> Other               |                                          |
| 5. At any time in the past 2 years, has seasonal/migratory farm work been your or your family's main source of income?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                |                                              |                                          |
| 6. Are you (patient) a United States Armed Forces veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                |                                                                                                                                                                |                                              |                                          |

## DEMOGRAPHIC INFORMATION (Fill out for self/patient)

|                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7. What is your (patient's) sex?                                                                                                                                                                                                                                                                                           |
| 8. Are you (patient) Hispanic and/or Latinx?<br><input type="checkbox"/> Another Hispanic, Latinx or Spanish Origin <input type="checkbox"/> Mexican, Mexican American, Chicanx <input type="checkbox"/> Puerto Rican<br><input type="checkbox"/> Cuban <input type="checkbox"/> Not of Hispanic, Latinx or Spanish Origin |
| 9. Describe your (patient) racial background. (American Indian, Black/African American, Chinese, Filipino, Japanese, Mam, White, etc.)<br>_____                                                                                                                                                                            |

\*\*\*For Future Use: Please initial and date below once you have reviewed this form at each annual review.\*\*\*

\_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_

|                 |               |      |
|-----------------|---------------|------|
| OFFICE USE ONLY | Completed By: | MRN: |
|-----------------|---------------|------|

## Patient Demographic Questionnaire

You may wonder why we need this information. North Olympic Healthcare Network is a **Federally Qualified Health Center (FQHC)**, a special type of community health center. We offer care to everyone, regardless of age, sex, ethnicity, or whether a patient has insurance or can afford to pay.

Your answers on this form help us:

- Understand our patients' emotional, financial and other needs
- Identify who may benefit from assistance
- Provide high-quality, personalized care
- Fulfill our mission as a community health center
- Meet our reporting requirements as an FQHC

### Your Answers Are Secure

**We keep your answers private and secure.** We only report them in a way that does not identify individuals.

## How to fill out the PDQ

Please read each question carefully and answer as best you can.

If you are filling out the form on behalf of another person (spouse, child, etc.):

- Please complete the **General Information** and **Demographic Information** sections based on the patient's information.
- Please complete the **Housing/Income** section based on the patient's household information.

## Reviewing the PDQ Each Year

Once each year we will ask you to review the information on this form.

If there are no changes, please initial and date in the space at the bottom of the form.

If you need to make changes, please put a line through the previous answer and fill in the check box of the new, corrected answer. Then initial and date in the space at the bottom of the form.

***Thank you for choosing North Olympic Healthcare Network for your healthcare needs!***