CROSS VALLEY HEALTH & MEDICINE

Modern Medicine. Old-fashioned personal care.

PATIENT INFORMATION

Patient's Legal last name: | Legal first name: | Middle:

Preferred name: | DOB:

Home address:

City: | State: | Zip Code:

E-Mail Address for Patient Portal: *Must be 18 years of age or older*

Today's Date:

Social Security Number:

Mailing Address (if different from home address)

Cell phone number:

Home phone number:

Work phone number:

Language Needs (Collected as a federal requirement):

☐ Check if you prefer to communicate in a language other than English.

Indicate language preference (including American Sign Language-ASL): _____

Veteran Status (Collected as a federal requirement)

Are you a veteran of the U.S. military? ☐ yes ☐ No

INSURANCE INFORMATION

☐ **I am insured (please provide a copy of your insurance card to the patient service representative)**

❶ *Primary Insurance Name:* _____ *ID#:* _____

Who is the primary subscriber? ☐ *patient/myself* ☐ *other- Name:* _____

If other, insured date of birth: _____ *Insured relationship to patient* _____

❷ *Secondary Insurance Name (if applicable):* _____ *ID#:* _____

Who is the primary subscriber? ☐ *patient/myself* ☐ *other- Name:* _____

If other, insured date of birth: _____ *Insured relationship to patient* _____

❸ Name of person who is financially responsible for healthcare payments (deductibles/co-pay's, etc.):

☐ Myself ☐ Other (please provide name) _____

HOW DID YOU HEAR ABOUT US?

☐ Internet ☐ Radio ☐ Insurance Company ☐ Newspaper/Magazine Ad ☐ Social Media

☐ Referral from a friend/family member

☐ Referral from my healthcare provider: Name and address of provider: _____

☐ this provider is also my Primary Care Provider

If provider above is <u>not</u> your primary care provider, please list primary care provider here: _____

_____

SIGNATURE

I certify that the above information is true and correct to the best of my ability.

Name of person completing this form: (print) _____

Signature _____

Relationship to patient: ☐ self ☐ parent ☐ legal guardian ☐ other: _____

Name:_____ Date of Birth:_____

GETTING TO KNOW YOU

We require the following information for the purposes of understanding our population better and to satisfy our reporting requirements to the federal government. The options for these questions were provided by those organizations which analyze this information, and in no way impact the care you receive. Please help us serve you better by selecting the best answer to these questions. Thank you.

Race (Collected as a federal requirement):

You may select one or more

☐ White/ Caucasian	☐ Black or African American	☐ Asian	☐ Native Hawaiian
☐ American Indian/ Alaskan Native	☐ Other Pacific Islander	☐ I Decline to provide this information	

Ethnicity (Collected as a federal requirement): Please select one

☐ Non-Hispanic ☐ Hispanic

☐ I Decline to provide this information

Sex assigned at birth (Select one) ☐ Male ☐ Female

Marital status (select one): ☐ Single ☐ Married ☐ Partnered/Other

(Collected as a federal requirement)

Sexual Orientation (Select one)	Gender Identity (Select one)
☐ Lesbian, gay or homosexual	☐ Male
☐ Straight or heterosexual	☐ Female
☐ Bisexual	☐ Transgender Male/Female to Male
☐ Something else/Other	☐ Transgender Female/Male to female
☐ Don't know	☐ Gender Queer
☐ Choose not to disclose	☐ Other
	☐ Choose not to disclose

Employment Status (Only for patients 18 years and older; Collected to assess potential exposures to health risks):

☐ Employed full-time ☐ Employed part-time Occupation: _____

☐ retired ☐ disabled ☐ student ☐ other ☐ I decline to provide this information

Emergency Contact:

1) **Name:** _____ **Phone #:** _____
   a. **Relationship:** _____

2) **Name:** _____ **Phone #:** _____
   a. **Relationship:** _____

Preferred Pharmacy:

Name: _____

Address: _____

Phone #: _____

Name_____ Date_____

Please list information in the spaces provided. Information is confidential and will not be released without your permission.

Medical Illnesses /Date (Example: Diabetes 1995)

_____
_____
_____
_____
_____
_____
_____

Operations / Procedures/ Hospitalizations / Dates
(Example: Tonsillectomy 1965, Pneumonia at Community Hosp 10/02)

_____
_____
_____
_____
_____

Indicate date last performed and if abnormal:

Pap_____
Mammogram_____
Colonoscopy _____
Stress test _____

Allergies (please indicate type of reaction)

_____
_____

Immunizations

Flu	Hepatitis
Pneumonia	Tetanus
MMR	Polio

Other_____

Personal- Social History (Please circle where appropriate)

Marital Status_____
Occupation_____
Hobbies / Interests _____
Hazardous material exposure_____

Smoking History

Never smoked / Past smoker / Present smoker
How many packs per day? _____
How many years? _____
Date stopped _____

Alcohol Use (Please circle)

Never to rarely /Light / Moderate / Heavy
Usual type of alcohol consumed _____
How much and how often?
_____

Substance Abuse Y N_____

Caffeine Y N Cups per day_____

Exercise Y N
Type and frequency _____

Family History (indicate blood relative who is affected)

Allergies_____
Arthritis / Gout_____
Asthma_____
Cancer _____
Diabetes_____
Emphysema_____
Gallbladder Disease_____
Glaucoma_____
Heart Disease_____
High Blood Pressure _____
High Cholesterol_____
Kidney Disease _____
Mental Illness_____
Migraine_____
Seizures _____
Stroke _____
TB _____
Thyroid Disease_____
Other _____
_____

Name_____ Date_____

Do you now or have you had any problems related to the following systems? **Please circle yes or no.**

Constitutional Symptoms
- Fever …….. Y N
- Chills……..Y N
- Headache……..Y N
- Unexplained Wt. Loss...Y N
- Wt. Gain……Y N
- Problems sleeping.....…..Y N
- Other_____

Endocrine
- Excessive thirst……Y N
- Too hot / cold..……Y N
- Tired / sluggish…….Y N
- Other_____

Eyes
- Blurred vision ……...Y N
- Double vision ……...Y N
- Eye pain ……Y N
- Other_____

Ear/Nose/Throat
- Ear infection……Y N
- Hearing loss……..Y N
- Sore throat……Y N
- Sinus problems…….Y N
- Other_____

Cardiovascular
- Chest pain……..…Y N
- Varicose veins……...Y N
- High blood pressure…..Y N
- Fainting spells……..Y N
- Leg cramps when walking…..Y N
- Other_____

Respiratory
- Shortness of breath……Y N
- Wheezing…..……Y N
- Frequent cough……..Y N
- Other_____

Gastrointestinal
- Abdominal pain……..……Y N
- Nausea/vomiting……...Y N
- Indigestion/heartburn…….Y N
- Change in bowel habits……..Y N
- Rectal bleeding/black stools...Y N
- Other_____

Genitourinary / Gyn
- Urinary frequency……..…..Y N
- Painful urination……..…Y N
- Incontinence……...Y N
- Blood in urine……..…....Y N
- Impotence……...Y N
- Pelvic pain……..…Y N
- Abnormal vaginal bleeding….Y N
- Abnormal discharge……Y N
- #of pregnancies_____ #of live births_____
- Other_____

Musculoskeletal / Neurological
- Joint pain / swelling……...Y N
- Neck pain……..…..Y N
- Back pain……...Y N
- Seizures……...Y N
- Numbness……..…..Y N
- Other_____

Hematologic
- Swollen glands……Y N
- Blood clotting problems…...Y N
- Other_____

Allergic / Immunologic/ Skin
- Rash……...Y N
- Itching……...Y N
- Hay fever……...Y N
- Other_____

Psychologic
- Do you feel depressed……...Y N
- Have you feel anxious/panic Y N
- Other_____

Medication List

Name of Medication	Dosage/Strength	Times of day you take this medication

Name:_____ Date of Birth: _____