Family First Health Care
Capac - Armada

DEMOGRAPHIC FORM

Today's date:	

PATIENT INFORMATION

Name (Last, First, MI):				Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Cell phone no.: ( )	SSN:	Birth date:	Sex: ❑ M ❑ F
Mailing Address:		City & State:		ZIP Code:
Street Address (*if different from above)*:		City & State:		ZIP Code:

E-mail Address: Referred By:

***☐ Yes, I would like to be able to update my health history and have access to my medical records through FFHC's online patient portal.

Race ☐American Indian or Alaska Native ☐Asian ☐Pacific Islander ☐African American ☐Caucasian ☐Hispanic ☐Other

Ethnicity ☐Hispanic or Latin ☐Not Hispanic or Latin **Language** ☐English ☐Spanish ☐Interpreter Needed

Pharmacy:_____ **City:**_____ Phone Number:_____

*Secondary Pharmacy:*_____ City:_____ Phone number:_____

*Mail Order Pharmacy:*_____Phone Number:_____

INSURANCE INFORMATION

Are you the primary insured? ☐Yes ☐No. If no please fill out the insurance information below for the primary insured:

Name of primary insured:

SSN:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No		Patient's relationship to the primary insured: ☐Self ☐Spouse ☐Child ☐Other:_____	

Name of Secondary Insurance (if applicable):

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

May staff members in our office speak to these people on your behalf regarding your medical information? ☐Yes ☐No

Emergency Contact Name:	Relationship to patient:	Phone no.: ( )
Emergency Contact Name:	Relationship to patient:	Phone no.: ( )

Patient/Guardian signature *Date*

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient Address: _____

I request and authorize: _____

To release/obtain healthcare information to/from:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

If the information described above includes information in any category below, *I specifically authorize the use or disclosure of such information.*

☐ Yes ☐ No STD results or HIV/AIDS testing, whether negative or positive
☐ Yes ☐ No Genetic Testing/Results
☐ Yes ☐ No Any records regarding drug, alcohol, or mental health treatment

I understand that I may revoke this authorization by notifying Family First at any time in writing, but if I do it won't have any effect on actions taken by Family First Health Care before they received the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (Except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used of disclosed pursuant to this authorization may be disclosed by the recipient and my no longer be protected by federal or state law.

I have read this form and all my questions about this form have been answered. By Signing below, I acknowledge that I have read and accept all of the above.

Patient/Guardian Signature: Date Signed:

_____ _____

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Patient Name _____

Date of Birth:_____

PEDIATRIC PATIENT HISTORY FORM

BIRTH HISTORY

Delivery: Vaginal Cesarean - due to:	Birth Weight:
Was this child premature? Yes No If yes, how many weeks? _____	Were there problems with this child's delivery? Yes No If yes, list:
Did this child have any unusual problems in the hospital such as trouble breathing, blue spells, yellow jaundice, trouble feeding, etc.? If yes, please list:	
Did this child need special treatment while in the hospital such as oxygen, transfusions, lights?	
Was (is) this child breast fed? No Yes	
Did (does) this child have any problems with breast feeding or formula feeding?	

SOCIAL HISTORY (Circle the appropriate answers)

Parents: Married Divorced Separated Single	
Siblings - please list:	
How many people live in your home? _____ Adults _____ Children	
Is your child currently enrolled in daycare or school? No Yes	
Does your child participate in regular exercise? No Yes explain:	
Does your child drink caffeine? No Yes	
Is there a swimming pool at home? No Yes	Any smokers at home? No Yes
Are there smoke detectors at home? No Yes	Carbon Monoxide detectors? No Yes
Any pets at home? No Yes If yes, please list:	
What is your water source?	Are guns kept in your home No Yes
Seat belts/car seats? No Yes	Helmets when biking? No Yes
Any issues we should be aware of? No Yes Please list:	

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

MEDICAL HISTORY	
Hospitalizations? None Yes - list:	
Surgeries? None Yes - list:	
Drug Allergies? None Yes - list:	
Did you bring a copy of child's immunization record? No Yes If no, please provide as soon as possible.	Hepatitis B Vaccine? No Yes
Has your child had chicken pox? No Yes If yes, when?	Has your child had chicken pox vaccine? No Yes
Any Chronic Illnesses: none yes - list:	Does your child see a specialist? No Yes Name?

REVIEW OF SYSTEMS		
Any lung problems?	None	Yes - list:
Any heart problems?	None	Yes - list:
Any kidney/urinary problems?	None	Yes - list:
Any bone/muscle problems?	None	Yes - list:
Any gastro-intestinal problems?	None	Yes - list:
Any brain/nervous system problems?	None	Yes - list:
Any genital problems?	None	Yes - list:
Any skin problems?	None	Yes - list:
Any eye/ear/nose/throat problems?	None	Yes - list:
Any developmental concerns or learining problems?	None	Yes - list:
Any behavioral problems or eating disorders?	None	Yes - list:
Any regular medications (over the counter or prescription)? Include does and frequency.		
Any medical issues we should be aware of? None Yes - list:		

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____

Patient Name _____ **Date of Birth:** _____

FAMILY MEDICAL HISTORY						
	Child's Father	**Child's Mother**	**Sibling**	**Sibling**	**Grandparent**	**Other**
Year of Birth (if known)						
Year of Death (if known)						
Cause of Death (if known)						
Heart Disease						
High Blood Pressure						
Stroke						
High Cholesterol						
Anemia						
Diabetes (note if onset as Adult or Child)						
Asthma						
Tuberculosis						
Cystic Fibrosis						
Alcohol Abuse						
Drug Abuse						
Mental Problems						
Social Problems						
Psychiatric Problems						
Cancer (type)						
Kidney Disease						
Migraines						
Seizures						
Congenital Birth Defects						
Eating Disorder						
Other:						
Other:						

COMMUNICATION NEEDS:

Language if other than English: Child _____ Parent(s)_____
Any special communication needs? No Yes
If yes, explain:_____

PATIENT RIGHTS:

Is there anything we need to know about your religion or culture in order to care for your child? _____Y _____N
If YES, explain:_____

Parents Initials: _____ Date: _____

Medical Provider's Initials:_____ Date: _____