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Welcome to Family Health Center! Where healthcare is a team approach with you, the patient, at the center of your own care.

Here are a few things you need to know:

- If your insurance requires you to designate a PCP please contact them **prior to your appointment** to let them know you have changed physicians or they may not pay for your visit. That means you may get a bill for the full cost of the visit.
- Please bring your insurance card and picture ID with you to your appointment.
- Regarding your previous medical records - We only need your most recent office visit and medication list, recent labs, recent radiology reports and any immunization records be sent to our office.
- If we do not have your new patient paperwork 24 hours prior to your appointment we may have to cancel your appointment. Please return your paperwork as soon as possible.
- If you are taking pain medications please talk with our front office staff.

Thank you for choosing Family Health Center for your medical needs!



Your New Medical Home

Family Health Center is a Patient-Centered Medical Practice dedicated to the health and wellness of the patients and community we serve. Our certification as a Patient-Centered Medical Home (PCMH) means our physicians and staff are committed to comprehensive, personal healthcare centered around you; partnering with you to ensure all of you and your family's medical and non-medical needs are met.

Your Personal Physician

The relationship between you, your physician, and the care team is the driving force behind a Patient-Centered Medical Home. Your physician will provide medical care that is right for you based on evidence-based guidelines shown to improve health.

Your Care Team

Your physician will direct the care team to coordinate your care based on YOUR wants and needs.

To improve efficiency, the care team will plan for your appointment by:

- ✓ reviewing your medical chart for up-to-date forms.
- ✓ check for recent testing.
- ✓ ensure you are notified of results in a timely manner.
- ✓ coordinate your healthcare across all care settings including the medical office, hospital, behavioural health, testing facilities and other places where you may receive care.

If you are admitted to the hospital, you will receive a phone call from your care team upon your discharge to review your hospital stay, make sure you return for follow-up care, and discuss any questions or concerns you may have about your treatment or medications.

Your Health

In return, we ask that you be an active participant in your health care. We ask that you take charge of your health by managing and monitoring aspects of your care.

You should:

- ✓ Let us know if there are any changes in your medications and bring a list of your medications with you to your visits.
- ✓ Let us know if you are getting care from other healthcare providers, any hospitalizations, or ER visits.
- ✓ Tell us about any complementary and natural treatments you are getting.
- ✓ Provide a complete medical history so you get the best care possible.
- ✓ Identify previous doctors so our medical records staff can request important notes and test results.

Quality for you

As a PCMH we are committed to providing same day appointments and offering expanded hours to meet your needs. We will use our electronic health record to support the best care, quality, and safety by helping us to identify and provide for your needs and the needs of our entire patient population. We are able to communicate with you electronically through our secure Patient Portal, along with sending you reminders for appointments and preventative or chronic care services due.

If you ever have any questions please just ask. Your care team is here to help!

Thank you for choosing Family Health Center as your Medical Home!

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Pediatric New Patient Paperwork

Child's Last Name: _____ First Name: _____ Middle Initial: _____ Nickname: _____

Birthdate: _____ Age: _____ Gender: _____ SS#: _____

Child's Mailing Address: _____ City: _____ St: _____ Zip: _____

Patient Insurance: _____ Policy #: _____

Mother's Name: _____ Birthdate: _____ Phone: _____

Mother's Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Email Address: _____

Employer's Name: _____ Work Phone: _____

Father's Name: _____ Birthdate: _____ Phone: _____

Father's Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Email Address: _____

Employer's Name: _____ Work Phone: _____

Does this child primarily live with: Father Mother Other Adult _____

Does this child at times live with adults other than above? Yes No

Name _____ Relationship _____

Address _____ Phone _____

What doctor / clinic have/has taken care of this child in the past? _____

Preferred Contact <input type="checkbox"/> Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Patient Portal <input type="checkbox"/> E-Mail Email address: _____	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic	Race <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other
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I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Family Health Center to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained heron are true. I understand that I am directly responsible for all charges incurred for medical services for dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also herby authorize Family Health Center to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

 Signature of Parent/Legal Guardian

 Date

 Printed Name of Parent/Legal Guardian

 Date

Acknowledgement of Notice of Health Information Practices

[We have made available to you our Notice of Health Information Practices. PLEASE REVIEW THIS NOTICE CAREFULLY! You may have a personal copy of the Notice, or you may access the Notice online at \[www.fhcsandpoint.com\]\(http://www.fhcsandpoint.com\).](#)

The Notice explains when we might use/disclose your health information, and includes some of the following examples:

- when you give us permission to disclose your health information
- to aid in your treatment or to persons involved in your health care or the payment for such
- to help us or other health care providers get paid for services provided to you
- to improve our health care operations
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- right to ask that information about you not be disclosed to certain persons
- right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your health information in our records
- right to request that we correct health information in your record that is wrong or misleading
- right to be notified when a breach of your health information has occurred
- right to have us tell you to whom we have disclosed your health information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility's Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Signature

Date

Printed name

Relationship to patient (if not the patient)/description of authority to act for patient: _____

FOR FHC USE ONLY:

Date Notice Made Available: _____ Notice Delivered: in person ___ mail ___ electronic ___

Acknowledgement Signed? Y or N

Why Acknowledgement Not Signed: patient refused ___ patient failed to return ___ emergency ___ other ___

Reason for today's visit: _____

Preferred Pharmacy: _____

Pregnancy and Birth

(Only fill out if child is currently younger than 12 months old)

Where was baby born? _____

Birth Weight _____ Birth Length _____ Age of Mother at Baby's birth _____

Infant's gestational age: Full term _____ Preterm _____ If so, how many weeks _____ Post term _____

Type of Delivery: Vaginal _____ C-section _____ If so, reason _____

Were there any medical problems during the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor), Labor or Nursery? _____

Did baby experience any jaundice? Y N

Did baby have their newborn hearing test? Y N

Did baby have their PKU test (also known as Newborn Health Screening / Heel Poke) Y N

Medications – List all medications your child takes, prescription and non-prescription, and the dosage

No Medications

Medication Name	Dosage	Frequency

Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)

No Allergies

Allergy	Reaction

Growth and Development

Are there any problems with the child's behavior in the home? Yes No If yes, please explain:

If child is old enough for school, are there any school problems (learning, social, behavioral, coordination)?

Yes No If Yes, please explain:

Has your child had any of the following?

	Yes	No	Date		Yes	No	Date
Anemia				Heart trouble / murmur			
Appendicitis				Inability to get to sleep?			
Asthma				Kidney disease			
Bladder infection				Loss of urinary bladder control?			
Bleeding with bowel movements				More than six colds in a year?			
Bloody, red or brown urine				More than two earaches in a year?			
Broken Bones				Pneumonia			
Chickenpox				Rheumatic fever			
Chronic cough/frequent bronchitis				Shortness of breath with exercise?			
Concussion(s)				Stuffy nose most of the time?			
Convulsions/seizures				Treated for accidental poisoning			
Eczema/sensitive skin				Tonsil-Adenoid surgery			
Fainting spells				Trouble hearing			
Frequent bad stomachaches				Unconscious from an injury			
Frequent nightmares				Weak eye muscles (cross eyes or wall eyes)?			
Frequent urination?				Whooping cough			
Frequent vomiting?				Other serious injuries: _____			
Headaches more than twice a month?				Hospitalized for reasons other than those listed: _____ _____			

Health and Safety

	Yes	No		Yes	No
Does your child get regular dental cleanings?			Is the hot water temperature set to less than 125 degrees?		
Does your child use a car seat or seat belt all the time?			Do you have rules/limits for screen time?		
Are there smoke detectors in your home?			Are medicines or potential poisons out of reach?		
If there are guns in your home are they locked up?			Is there an adult in your household who knows child CPR?		

Family History – Check if any family member(s) has had any of the following conditions

Are child adopted? Yes No

Relationship	Significant Health Problems (Circle all that apply)
Grandmother (Maternal) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Grandfather (Maternal) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Grandmother (Paternal) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Grandfather (Paternal) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Father Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Mother Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Sister(s) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____
Brother(s) Alive? Yes No If No, what was cause of death? _____ _____	Alzheimer's Arthritis Asthma Blood disorder Depression Diabetes Heart Attack Heart disease High Cholesterol Renal Disease Stroke Thyroid Disorder Cancer, Type: _____

Is there anything else we should know about your child's medical history?
