MRN #:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Kentucky Mountain Health Alliance, Inc.**

**New / Updated Patient Assessment**



**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_**

**SS#: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**If patient is a minor, please fill out guardian information below!!!**

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| --- |
| **Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_-\_\_\_** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PLEASE FILL ALL INFORMATION OUT** | | | | | | |
| **Gender at Birth:** | **\_\_\_\_\_Female \_\_\_\_\_Male** | | | | | |
| **Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Race:** | **\_\_\_\_\_Asian \_\_\_\_\_Native Hawaiian \_\_\_\_\_Black/African American \_\_\_\_\_American Indian \_\_\_\_\_White \_\_\_\_\_More than once Race \_\_\_\_\_Unreported** | | | | | |
| **Ethnicity:** | **Hispanic/Latino \_\_\_Yes \_\_\_No** | | **US Veteran: \_\_\_Yes \_\_\_No** | | **Tobacco Use: ­­­\_\_\_Yes \_\_\_No** | |
| **Language: \_\_\_\_ English \_\_\_\_ Spanish \_\_\_\_ Other** | | | **Marital Status: \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Single**  **\_\_\_\_Widowed \_\_\_\_Separated** | | | |
| **MEDICAL HOME** | | | | | | |
| **Are you receiving services from any other healthcare/mental health agency? \_\_\_\_\_Yes \_\_\_\_\_No**  **If yes, please list agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **INSURANCE** | | | | | | |
| **□None (Self-Pay) □**Medicaid**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Medicare: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **□Commercial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □Private: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **RESPONSIBLE PARTY (If different from patient)** | | | | | | |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **EMPLOYMENT STATUS (Please Check One)** | | | | | | |
| Full Time: \_\_\_\_\_\_\_\_\_\_\_\_\_  Disable: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Part Time: \_\_\_\_\_\_\_\_\_\_\_\_\_  Not Employed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Retired: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **HOUSEHOLD INCOME (To determine eligibility for our Sliding Fee Scale, even if you have insurance)** | | | | | | |
| **Source (SSI, SSDI, Black Lung, Wages, Retirement, Child Support, etc.)** | | | **Monthly** $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Annually $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Do you get Food Stamps? Yes\_\_\_\_\_No\_\_\_\_\_\_ Number in Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_