Primary: _____ Dental: _____ Prenatal:_____

Patient Registration Form (*2 pages*)

New ☐ **Annual** ☐

Home Location: ☐ Families First ☐ HH ☐ Goodwin Community Health ☐ Lilac City Pediatrics

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Gender (at the time of birth): ☐ M ☐ F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ **Okay to leave a voicemail?** ☐ Yes ☐ No

Cell Phone: (_____) _____ **Okay to text you?** ☐ Yes ☐ No **Okay to leave a voicemail?** ☐ Yes ☐ No

Email Address: _____ (Portal access available upon request)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Gender Identity: ☐ M ☐ F ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Race: ☐White ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐Black/African American ☐American Indian ☐More than one race ☐Other_____

Living Arrangements: ☐Rent ☐Own ☐Stay w/relatives/friends ☐Shelter ☐Other temporary housing _____

Language: _____ **Are you Deaf?** ☐ Yes ☐ No *An interpreter can be provided during medical visit upon request*

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Veteran Status:** ☐Veteran ☐Non-Veteran **U.S Citizen** ☐Yes ☐No

PARENT / GUARDIAN INFORMATION (Complete if patient is under 18 years old)

1.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient (circle one): Mother Father Other (please fill in): _____ Sex: ☐ M ☐ F

2.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient (circle one): Mother Father Other (please fill in): _____ Sex: ☐ M ☐ F

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: (_____)_____

1. Okay to speak with regarding your appointments? ☐ Yes ☐ No 2.Okay to speak with regarding your medical care? ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone: (_____)_____

1. Okay to speak with regarding your appointments? ☐ Yes ☐ No 2.Okay to speak with regarding your medical care? ☐ Yes ☐ No

Preferred Local Hospital: _____

***COVERAGE MAY REQUIRE NOTIFYING THE INSURANCE CARRIER OF YOUR PROVIDER. THIS IS THE RESPONSIBILITY OF THE PATIENT.** _____**(Initials)**

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Subscribers Name: _____ Subscribers DOB: _____ Relationship to Patient: _____

Secondary/ Dental Insurance Name: _____ Policy #: _____ Group #: _____

Subscribers Name: _____ Subscribers DOB: _____ Relationship to Patient: _____

1. How did you hear about us? _____ **(New Patients only)**
2. Are you transferring your care from another medical office? ☐ Yes ☐ No If yes, where? _____

Patient / Guardian Signature: **X** _____ Date: _____ (OVER) -->

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

FEE DETERMINATION

FOR OFFICE USE - PATIENT NOTIFICATION
☐ **APPROVAL** ☐ **DENIAL**
Sliding Fee Category & Discount: _____/_____
Expires: _____

Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

IF YOU DO NOT WISH TO APPLY: Please provide the information and signature requested below. This helps us meet the requirements of the state and federal grants we receive. Family size:_____ Annual household income: $_____

☐ I do not wish to apply for the sliding fee discount. Patient/guardian signature: _____ Date: _____

TO APPLY FOR THE SLIDING FEE DISCOUNT: Please fill in the table below and supply proof of income within the next 30 days. Discounts are based on family size and household income. We will tell you what your sliding fee category and discount are, and you will be eligible for this discount for one year. (After one year, you will be asked to submit proof of income again.)

Examples of *types* of income:
- Social Security
- Retirement
- Business
- Welfare payments
- Child support
- Alimony
- Disability
- Others

Examples of *proofs* of income:
- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of unemployment check stubs

Please provide the information requested below for yourself and all persons living with you.

Name (First, MI, Last)	Sex	Relationship to you	Date of Birth	Income and Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
	Family Size:		**Household Income:**	$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if information provided is found to be inaccurate, any discount given may be reversed.

Patient/Guardian Signature **X**_____Date:_____

☐ I would like a free appointment to understand the insurance options available to me.

OFFICE USE ONLY:

Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Basic Dental Payments:	❒ $40	❒ 50%	❒ 65%	❒ 80%	❒ Full Pay
Major Dental Payments:	❒ $40+	❒ 60%	❒ 75%	❒ 90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused

Staff Name: _____ Date: _____

Reviewed by: Front Office Supervisor or Authorized Designee * Verification and Approval is reflected with initials, date and category directly on the income (subject to additional review).

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Date: _____

HEALTH HISTORY FORM *(2 pages)*

NAME: _____ M ☐ F ☐ DOB: _____

YOUR ANSWERS ON THIS FORM WILL HELP YOUR HEALTH CARE PROVIDER BETTER UNDERSTAND YOUR MEDICAL CONCERNS AND CONDITIONS. IF YOU ARE UN-COMFORTABLE WITH ANY QUESTION, DO NOT ANSWER IT. IF YOU CANNOT REMEMBER SPECIFIC DETAILS, PLEASE PROVIDE YOUR BEST GUESS. THANK YOU!

Who was your previous primary care provider:_____

Date last seen by above provider: _____

Do you currently have a Dental provider (circle one)? ☐ Yes ☐ No

Please list the names and specialty of any other providers ***currently*** involved in your care

Provider Name	Specialty

ALLERGIES: ☐ No Known Allergies ☐ Allergies listed below

ALLERGY:	REACTION:

CURRENT MEDICATIONS: PRESCRIPTION AND NON-PRESCRIPTION MEDICINES, VITAMINS, HOME REMEDIES, BIRTH CONTROL PILLS, HERBS, ETC.

MEDICATION:	DOSE: (e.g., mg/pill)	HOW MANY TIMES A DAY AND WHEN?

HOSPITILIZATION HISTORY: PLEASE LIST ALL PRIOR

REASON FOR HOSPITAL STAY:	HOSPITAL NAME:	DATES OF STAY: (EXACT OR APPROXIMATE)

SURGICAL HISTORY: PLEASE LIST ALL PRIOR

SURGERY/OPERATION TYPE:	WHERE SURGERY WAS DONE:	DATES OF SURGERY: (EXACT OR APPROXIMATE)

NAME:_____ DOB: _____

BIRTH HISTORY: *Please complete if your child is 5 or younger*

Birth Weight: _____ Was the baby on time: ☐ Yes ☐ No

Did the mother have any illness during pregnancy: ☐ Yes ☐ No

Did the baby have any trouble in the hospital after delivery? (ie jaundice, infection, breathing trouble) ☐ Yes ☐ No

If yes to above question, please describe:_____

How was your baby delivered: ☐ Vaginal Delivery ☐ Cesarean Section (please list reason for c-section)_____

PERSONAL MEDICAL HISTORY: PLEASE INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS (WITH DATES):

☐ Acid Reflux/GERD	☐ Chronic Pain	☐ High Cholesterol
☐ ADHD	☐ Depression	☐ Irritable Bowel
☐ Alcoholism	☐ Diabetes	☐ Kidney Disease
☐ Allergies	☐ Emphysema/Bronchitis/COPD	☐ Liver Disease
☐ Anemia	☐ Epilepsy/Seizure Disorder	☐ Mental Health Issues
☐ Anxiety	☐ Glaucoma/Cataracts	☐ Osteoporosis
☐ Arthritis	☐ Headaches	☐ Stroke
☐ Asthma	☐ Hearing Loss	☐ Substance Abuse
☐ Bleeding Disorders	☐ Heart Disease	☐ Thyroid Disease
☐ Cancer	☐ High Blood Pressure	
☐ Other		

Home:

Who lives in your home?

Are there guns in home? ☐ Yes ☐ No

Do you worry about not having enough food? ☐ Yes ☐ No

Please complete if your child is 17 or younger:

Mother: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated

Father: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated

Siblings:

Pets in home:

INDICATE FAMILY MEMBERS WITH ANY OF THE FOLLOWING CONDITIONS:

HEALTH CONDITION	RELATIVE(S)
☐ Alcoholism	
☐ High Cholesterol	
☐ Cancer (Specify Type):	
☐ High Blood Pressure	
☐ Heart Disease	
☐ Stroke	
☐ Depression/Suicide	
☐ Bleeding/Clotting Problem	
☐ Asthma/COPD	
☐ Diabetes	
☐ Thyroid Problem	

SOCIAL HISTORY:

TOBACCO USE

Cigarettes ☐ Never ☐ Quit (Date):

Current: Packs/day: _____ # of year _____

Other ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

ALCOHOL USE

Do you drink alcohol? ☐ Yes (Drinks /Wk): ☐ No

DRUG USE

Do you use any recreational drugs? ☐ Yes ☐ No

Have you ever injected drugs? ☐ Yes ☐ No

SEXUAL ACTIVITY

Currently sexually active? ☐ Yes ☐ No

Sexually active in the past? ☐ Yes ☐ No

Current sex partner(s) is/are: ☐ Male ☐ Female

History of STDs (sexually transmitted disease) ☐ Yes ☐ No

DIET, EXERCISE AND LIFESTYLE

Caffeine: ☐ Coffee/tea/soda (cups/day): ☐ None

Are you satisfied with your body weight? ☐ Yes ☐ No

How many days a week do you exercise?

Do you follow a special diet? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date:_____