New Patient Intake Form

PATIENT INFORMATION

Name: _____ **Age:** _____
(Last) (First) (Middle Initial)

Date of birth: (mm/dd/yyyy)**:** _____/_____/_____ **SSN** (*Optional*)**:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home phone: (_____)_____ **Cell phone:** (_____)_____

E-mail: _____@_____

Gender:
□ Male □ Female
□ Check if gender assigned on original birth certificate is different than current gender
□ Genderqueer, neither exclusively male or female
□ Additional Gender Category/ (or Other), please specify:_____
□ Choose not to disclose

Sexual Orientation:
□ Homosexual □ Bisexual □ Something else
□ Does not know □ None of the above □ Choose not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race (Mark all that apply.)
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Hispanic
☐ White
☐ Other Race
☐ Other Pacific Islander
☐ Unreported/Refused to Report

Are you **Hispanic** or **Latino?**
(Cuban, Mexican, Puerto Rican,
South or Central American,
other Spanish origin)
☐ Yes ☐ No ☐ Refused to Report

Are you a:
☐ **migrant worker**
☐ **seasonal worker**

Are you a **veteran**?
☐ Yes ☐ No

Do you need interpretation services in a **language other than English**?

☐ Yes ☐ No

If **yes**, please specify language:

_____

Are you **homeless?**

☐ Yes ☐ No

Do you live in **public housing**?

☐ Yes ☐ No

Including yourself, **how many people live in your household**?

_____ people

Monthly Household Income:

☐$0-$300	☐$301-$500	☐$501-$700	☐$701-$1,000
☐$1,001-$1,500	☐$1,501-$2,000	☐$2,001-$2,500	☐$2,501-$3,000
☐$3,001-$3,500	☐$3,501-$4,000	☐$4,001 or above	☐Decline to Answer

If the patient is **under 18 years old**, please write the name of a parent or guardian:

Name:_____

CPACS is a non-partisan agency that offers assistance with voter registrations.
You can register to vote if you meet all of the following qualifications:

- You're a U.S. citizen and a resident of Georgia;
- You'll be at least 18 years old Election Day;
- You're not serving a sentence for a felony conviction;
- You haven't been declared by a court to be "mentally incompetent."

Would you like help with registering to vote? □ Yes □ No

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: (_____)_____

Address: _____

EMERGENCY CONTACT

Name: _____
(Last) (First)

Relationship: _____ Phone: (_____)_____

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Primary insurance: _____

Policy no.: _____

Group no.: _____

Phone: (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

Secondary insurance: _____
(If applicable)

Policy no.: _____

Group no.: _____

Phone: (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

MEDICAL HISTORY

Name: _____

DOB: _____

Are you allergic to medicine, food, or environmental allergens? ☐ Yes ☐ No

If **yes**, please specify:

_____

_____

Do you currently smoke cigarettes (including smokeless cigarettes)? ☐ Yes ☐ No

If **yes**, how much do you smoke on average?

_____ cigarettes/day

Do you drink alcohol? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY: Check if you had or have any of the following medical conditions listed below:

- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ AIDS or HIV positive
- ☐ Alcoholism
- ☐ Allergies or hives
- ☐ Anemia or blood disorders
- ☐ Arthritis
- ☐ Artificial joint or valve
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer or tumor
- ☐ Diabetes
- ☐ Emotional condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Hay fever or sinus trouble
- ☐ Heart disease or angina
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Hepatitis or other liver disease
- ☐ Herpes, cold sores, or mouth ulcers
- ☐ High or low blood pressure
- ☐ Kidney disease
- ☐ Migraine headaches or frequent headaches
- ☐ Neurologic condition
- ☐ Pacemaker
- ☐ Radiation treatment
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Tuberculosis or other lung problems
- ☐ Other:

_____

_____

CURRENT MEDICATION: Please **list** all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PATIENT SURGICAL HISTORY:

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY:

_____

_____

_____

_____

_____

_____

WOMEN ONLY:

Are you **pregnant**? ☐ Yes ☐ No

If **yes**, expected delivery date:

_____

Are you taking **hormones** or **contraceptives**?

☐ Yes ☐ No

If **yes**, please specify:

_____

ASSIGNMENT OF BENFITS

I hereby assign all medical and surgical benefits to including major medical benefits to which I am entitled including Medicare, private insurance, and any other health plan to CPACS-Cosmo Health Center/ Dental Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the assignee to release all information necessary to secure payment.

PATIENT CONSENT FOR USE AND DISCLUSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for CPACS Cosmo Health Center (Cosmo) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (CPACS Cosmo Health Center Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by a written request to:

Administrative Office	Service Site
Center for Pan Asian Community Services	**CPACS Cosmo Health Center**
3150 Shallowford Rd NE	6185 Buford Hwy Building A&G
Atlanta, GA 30341	Norcross, GA 30071

With this consent, Cosmo may call my home or alternate location and leave a message in reference to any items that assist the health center in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Cosmo may mail to my home or other alternate locations any items that assist the practice in carrying out TPO, such as letters and patient statements.

With this consent, Cosmo may send mails to my home or other alternative locations utilizing *eClinicalWorks,* our electronic medical records system which assists the practice in carrying out TPO.

I have the right to request that Cosmo restrict how it uses or disclose my PHI to carry out TPO. However, the health center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Cosmo to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cosmo may decline to provide treatment to me.

I understand that I can receive Title X Family Planning services confidentially and voluntarily regardless of my ability to pay.

Restrictions on disclosure (OPTIONAL): _____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Prescription History & ePrescribing Consent Form

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at CPACS Cosmo Health Center as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at CPACS Cosmo Health Center may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to CPACS Cosmo Health Center to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name	Patient DOB
Signature of patient or guardian	Today's Date
Relationship to Patient	

Skip the form for children **under 12** years of age

Patient Health Questionnaire (English)

Name: _____ **DOB:** _____ **Date:** _____

A. Little interest or pleasure in doing things ☐ **Yes** ☐ **No**

B. Feeling down, depressed, or hopeless ☐ **Yes** ☐ **No**

If you answered "No" to **BOTH** A and B, STOP **STOP HERE.**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer.)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite--being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
FOR OFFICE CODING	0	+_____	+_____	+_____
			=Total Score: _____	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**