Lahai HEALTH

Annual Patient Update Form 2020

PATIENT INFORMATION

Name: _____ (LAST/SURNAME), _____ (FIRST) Middle Initial: _____

Date of Birth: _____ (MONTH) / _____ (DAY) / _____ (YEAR) Age: _____

Gender: ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male ☐ Gender Nonconforming
☐ Other gender identity not listed above: _____ ☐ Prefer not to answer

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Were you homeless or had unstable housing within the last 12 months? ☐ No ☐ Yes

Language(s): _____ Interpreter Needed: ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity:

☐ African
☐ African-American/Black
☐ Asian
☐ Pacific Islander
☐ Caucasian
☐ Latino/Latina
☐ American Indian/ Alaska Native
☐ Arab/Middle Eastern
☐ Multiracial
☐ Unknown

CONTACT INFORMATION

Phone (Primary): _____ ☐ Cell ☐ Home ☐ Other: _____

Phone (Secondary): _____ ☐ Cell ☐ Home ☐ Other: _____

We may need to contact you. Please check all that we have your permission to leave messages on or with:

☐ Voicemail/Texting

☐ Check here to opt out of receiving text messages

☐ SPECIFIC Person ONLY, provide the name(s): _____

☐ Another Person: _____

Please list an EMERGENCY contact below:

_____ (NAME), _____ (RELATIONSHIP), _____ (PHONE)

CURRENT MEDICATIONS:

Please list your current medications:

1. _____
2. _____
3. _____
4. _____

HEALTHCARE RECORDS *(in the last year)*

Have you received care from any other medical clinic/provider? ☐ No ☐ Yes (**If yes**, provide the info below).
Clinic/Provider Name: _____ Phone: _____

Have you had any hospitalizations or ER visits? ☐ No ☐ Yes (**If yes**, please list the reason/date below).

1. _____, Date: _____
2. _____, Date: _____

The following sections are required to determine if you might qualify for other free or low cost health services, referrals, and medication assistance. It is also required by organizations that donate free labs/imaging/supplies to our clinic

INSURANCE INFORMATION:

HEALTH:

Do you have any forms of health insurance right now? ☐ No ☐ Yes

If yes, please identify the type of coverage you have below and *provide a copy of your card to reception.* Common types are

(*Medicaid/Apple Health, Medicare, Veteran Benefits, or contracted from the Health Exchange*)

Insurance Plan: _____ **Yearly Deductible: $**_____

If no, have you ever applied for Health insurance? ☐ No ☐ Yes Date Applied: _____

(If you applied and were denied coverage, please provide a copy of denial letter to reception.)

DENTAL:

Do you have any dental insurance? ☐ No ☐ Yes

If yes, please identify what type of insurance you have and provide a copy of your card to reception (Medicaid/Apple Health, Delta Dental, etc.)

Dental Insurance: _____

HOUSEHOLD INFORMATION:

Country or Origin: _____ **Years in US:** _____ **Are you a visitor?** ☐ Yes ☐ No

If Yes: What is the date of arrival: _____Date of Departure: _____

Reason for visit: (Refugee/Asylee, Family, Type of Visa, etc: _____

(If you are applying for asylum, please provide a copy of Asylum application to reception)

Your annual income and your family size are necessary to determine your eligibility. Your answers will be kept on file and in strict confidence.

Please choose 1 from the list below to verify your income:

- *Income tax return from the previous year*
- *A copy of your W-2 form*
- *Two months of paycheck stubs*
- *Two months of bank statements*
- *Copies of your social security checks or letter, or other checks you may receive.*

You must verify your income every year. Please bring a copy to your appointment.

Are you employed? ☐ No ☐ Yes	Patient's Monthly Employment Income:
Is your spouse/partner employed? ☐ N/A ☐ No ☐ Yes	Spouse/Partner's Monthly Employment Income:
How many people are supported with the total household income? _____	

Does anyone else in your household have any form of income that supports you (spouse, parent, etc.)? If so, please fill out the following:

Other Income	
Social Security:	$
Food Stamps:	$
Public Assistance:	$
Retirement Pension:	$
Child Support, Alimony:	$
Other:	$
TOTAL:	$

I do hereby swear or affirm that the information provided above is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for programs at Lahai Health. I further agree to inform Lahai Health if there is a significant change in my income. If acceptance to the Lahai Health programs is obtained under this application, I will comply with all rules and regulations of Lahai Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

RECEPTION USE ONLY:

☐ Patient Privacy Handout, Missed Appointment Handout given
☐ Review Profile Section on Practice Fusion for completeness
☐ Clinic Site: _____
☐ Copy of Identification (ID) provided (*indicate type*): _____
☐ Financial Documents provided (*indicate type*): _____
☐ Copy of Insurance Cards provided (*only for patients with any insurance*)
☐ Explanation of Financial Standing form completed (*if applicable*)
☐ ROI for dental/medical records completed (*if needed*)
☐ Signed medical interpreter form (if applicable indicate type): _____
☐ Signed Text Messaging(SMS) consent (if applicable)
☐ Specify what percentage patient falls under the Federal Poverty Level (*Refer to the FPL chart*): _____%