Lahai HEALTH

New Patient Intake Form 2020

DENTAL USE ONLY:
80% 60% 40%

PATIENT INFORMATION:

Name: _____ _____ Middle Initial: ____
(LAST/SURNAME) (FIRST NAME)

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

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: _____

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

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed Veteran: ☐Yes ☐No

Race/Ethnicity:

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

_____ _____ _____
(FULL NAME) (PHONE) (RELATIONSHIP)

Please list any **hospitalizations, surgeries, or ER visits** you have had.

1. _____ Date: _____ 3. _____ Date: _____

2. _____ Date: _____ 4. _____ Date: _____

Staff Initials:_____ Patient Name: _____INTAKE 1

Formerly PUGET SOUND CHRISTIAN CLINIC

MEDICAL/DENTAL RECORDS:

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

☐ Dental ☐ Medical ☐ Mental Health Counseling ☐ Current ☐ Previous

Clinic/Provider Name:

Address:

Phone: Fax:

Do you have dental, medical, or mental health counseling records that you would like to have sent to us from past or current clinics?

☐ *No* ☐ *Yes (Please ask reception for a Release of Information form and we will request the records)*

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:

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)

HOUSEHOLD INFORMATION:

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 Digital Signature: _____ Date: _____

PATIENT PRIVACY AGREEMENT

This notice describes how your medical and personal information may be used and disclosed at Lahai Health. Your protected private information includes personal and demographic information such as your name, address, date of birth, various identification numbers and phone numbers. It also includes all health information relating to your past, present, and future physical or mental health conditions.

We use and disclose your private information in many ways when providing you with care. If our healthcare providers ask you to see a specialist, we may disclose your name and reason for referral to the specialist. If a pharmacy calls us with a refill request, we may confirm your information with them. When we send a specimen to the laboratory, we disclose your name and other demographic information to them. This type of disclosure between our healthcare providers and other care providers is necessary to provide you with the best and most effective care. Your primary health care team may include, but is not limited to: providers, nurses, dietitians, spiritual care & physical therapists.

There are situations where we may release your information without your expressed consent. These situations include but are not limited to: emergencies, required reporting to public health entities, and as required by law enforcement agencies. You may have rights regarding our use of your private information. You have the right to limit disclosure (in writing) of your information. You have the right to know if we disclose your information for non-routine health care purposes. You have the right to see your medical records and request amendments or corrections. This notice will be kept on file. You may file a complaint regarding the disclosure of your information to our Clinic Director.

I have read and understand the agreement above between Lahai Health and myself regarding the privacy of my information. This agreement will remain in effect until it is revoked in writing by the undersigned.

Patient Digital Signature: _____ Date: _____

CONSENT FOR DENTAL, MEDICAL or COUNSELING TREATMENT

Choose all that apply: ☐ Dental ☐ Medical ☐ Mental Health Counseling

In order to receive quality care, I authorize the release of my medical, dental or mental health counseling information to Lahai Health in order to provide me with care. I authorize Lahai Health to release my medical records to other health care providing agencies for the purpose and benefit of providing health care to me.

I hereby give consent to receive medical, dental or counseling care from Lahai Health and its providers and healthcare staff. If patient is a minor, the patient's parent/guardian must consent to care and treatment. I understand that there are exceptions when care can be obtained by a minor without parental or guardian consent, based on Washington State law and Federal law.

The information provided on my intake paperwork is accurate to the best of my knowledge and I will inform Lahai Health of any changes in my health, medications, health insurance status, income or contact information.

Privacy Practices are listed above in the "Patient Privacy Agreement". I understand that I can obtain a personal copy, upon request.

This authorization will remain in effect for any care received through Lahai Health until it is revoked in writing by the undersigned.

Patient Digital Signature: _____ Date: _____

LAHAI HEALTH MISSED APPOINTMENT POLICY

It is important that Lahai Health patients keep their appointments. When a patient doesn't show up for a scheduled appointment, cancels last minute, or arrives late, the clinic's *very limited resources* are wasted when Lahai Health could have served another patient in need of care.

Rescheduling Appointments

To reschedule, please call Lahai Health (206-363-4105 MEDICAL: Ext 230, DENTAL: Ext 701, COUNSELING: Ext 231) as soon as you know that you will not be able to keep the appointment, ***at least 24 hours prior to your appointment time***. Please leave a message on the scheduling line if your call is not answered.

Missed Appointments

If you miss a scheduled appointment completely, cancel with less than 24 hours' notice, or arrive more than 10 minutes late, this will be recorded in your electronic chart. Please note if you arrive late, you may have to be rescheduled, if there is not enough time to complete your visit or procedure.

If you have 2 missed appointments (includes late cancels or late shows) within a 1-year time frame, you will not be able to schedule with Lahai Health for a period of 6 months. You will receive a letter from clinic staff notifying you of the date you may return for care.

I understand the Lahai Health Missed Appointment Policy and agree to follow the terms of this policy.

Patient Digital Signature: _____ Date: _____

*WHEN PAGES 1-5 ARE COMPLETE, PLEASE HAND TO THE RECEPTIONIST WITH A FORM OF ID, ANY INSURANCE CARDS, AND FINANCIAL DOCUMENTATION YOU BROUGHT. *

RECEPTION USE ONLY:

- ☐ 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*): _____%

☐ FOR DENTAL USE ONLY: Circle what percentage discount the patient is approved for: 80% 60% 40%

SOCIAL HISTORY:

Where are you currently living? ☐House ☐Apartment ☐Car ☐Homeless/Unstable Housing ☐Other: _____

Do you feel safe in your current relationship? ☐No ☐Yes

Sexual Orientation: ☐Heterosexual ☐ Homosexual ☐Bisexual ☐ I prefer not to answer.

Number of Lifetime Sexual Partners: _____ Number of Sexual Partners in the Last Year: _____

Use of Caffeine (Coffee/Tea/Soda): ☐ Never ☐ Rarely ☐Moderate ☐ Daily ☐Previously, but I quit.

Use of Alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily ☐Previously, but I quit.

Use of Tobacco: ☐ Never ☐ Rarely ☐Moderate ☐ Daily ☐Previously, but I quit.

Use of Marijuana: ☐ Never ☐Rarely ☐Moderate ☐Daily ☐ Previously, but I quit.

Use of Recreational Drugs: ☐ Never ☐Rarely ☐Moderate ☐Daily ☐Previously, but I quit.

Exercise: ☐Never ☐Rarely ☐Moderate ☐Daily, Types of Exercise: _____

SPIRITUAL CARE:

Would you like for someone to pray with/for you or help with faith-based questions? ☐ Yes ☐No

Do you have other concerns? (For example: Housing, food stamps. Financial assistance, or transportation): ☐Yes ☐No
If you answered yes to any of the above, please ask receptionist to speak with the patient advocate.
(**Dental:** please ask receptionist.)

***How did you hear about Lahai Health? ☐Online ☐Goodwill Screening ☐Church: _____
☐ Lahai Health Volunteer ☐Family/Friends ☐Other: _____

CURRENT MEDICATIONS:

Please list all medications (prescriptions, over the counter, vitamins and supplements). For additional medications, please attach separate sheet.

Name of Medication:	Dosage: (mg/ml)	Frequency:	Date Started:	Prescribed By:

Please indicate your preferred pharmacy:

Pharmacy:

Address:

Phone: Fax:

MEDICAL INFORMATION:

Please indicate any medical problems YOU have experienced and indicate the date/year.

Date	Medical Problem	Date	Medical Problem	Date	Medical Problem
	Alcohol/Drug Problem		Osteoporosis		Liver Problem
	Allergies/Hay Fever		Diabetes		Seizures
	Arthritis		Depression or Suicide Attempt		Mental Health (Bipolar, Schizophrenia, etc.)
	Asthma/Emphysema		Glaucoma		Stroke
	Bladder or Kidney Infections, Kidney Stones		Heart Disease or Heart Attack		Sexually Transmitted Disease
	Bleeding/Clotting		High Blood Pressure		Thyroid Condition
	Cancer (specify below)		High Cholesterol		Tuberculosis

FAMILY MEDICAL HISTORY:

Please indicate anyone in your FAMILY who has or had the conditions below.

Alcohol/Drug		Cancer (type)		Mental Illness	
Allergies		Cholesterol		Migraines	
Alzheimer		Depression		Nerve Disorder	
Arthritis		Diabetes		Obesity	
Asthma		Eye/Ear Problem		Lung Problem	
Blood Disease		Genetic Disorder		Sickle Cell	
Bladder/Kidney		Stomach/Intestine		Stroke	
Blood Pressure		Heart		Thyroid	

ALLERGIES

☐ I have no allergies. ☐ Yes, I have allergies. (***If yes**, please list allergy and reaction below.*)

1. _____ (ALLERGY) _____ (REACTION)
2. _____ (ALLERGY) _____ (REACTION)
3. _____ (ALLERGY) _____ (REACTION)

PAST MEDICAL:

Last visit to a doctor/provider: _____

Last visit to a dentist: _____

Last Complete Physical: _____

Eye exam/Glaucoma Check: _____

Tetanus Vaccine: _____

Women ONLY:

Last PAP smear: _____

Abnormal PAP History? ☐ No ☐ Yes

Last Mammogram: _____

# of Pregnancies: _____

Miscarriages/Abortions? ☐ No ☐ Yes

Age at Menopause: _____

Please list any current Medical Diagnoses:

1. _____ Date Diagnosed: _____
2. _____ Date Diagnosed: _____
3. _____ Date Diagnosed: _____

CURRENT SYMPTOMS: Please check all boxes that apply to you.

CONSTITUTIONAL SYMPTOMS:

☐ Unexplained weight loss or gain
☐ Fever or chills
☐ Night sweats/hot flashes
☐ Fatigue

HEMATOLOGICAL/LYMPHATIC

☐ Bleeding or bruising tendency
☐ Swollen glands

EYES/EARS/NOSE/THROAT

☐ Changes in vision
☐ Hearing loss or ringing
☐ Ear aches or drainage
☐ Chronic sinus problems or Hay Fever
☐ Recurrent nose bleeds
☐ Bleeding gum
☐ Sore throat or voice change or hoarseness

RESPIRATORY

☐ Chronic, frequent coughs
☐ Shortness of breath
☐ Asthma or wheezing
☐ Tuberculosis, positive TB skin test
☐ Spitting up blood

CCARDIOVASCULAR

☐ Heart trouble/heart murmur
☐ High blood pressure
☐ Chest pain or angina pectoris
☐ Palpitations (fast or irregular heartbeat
☐ Shortness of breath in walking/lying flat
☐ Swelling of feet, ankle or hands
☐ Swelling of feet, ankle or hands
☐ Rheumatic fever

NEUROLOGICAL:

☐ Frequent or recurring headaches
☐ Light headed or dizzy
☐ Convulsions or seizures
☐ Numbness or tingling sensations
☐ Paralysis
☐ Memory loss or confusion
☐ Nervousness
☐ Insomnia

ENDOCRINE

☐ Thyroid disease
☐ Diabetes, excessive thirst or urination
☐ Other grandular or hormone problem

URINARY

- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Incontinence or dribbling
- ☐ Sexual difficulty
- ☐ Kidney or bladder infections

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Painful bowel movements or constipation
- ☐ Regular laxative use
- ☐ Rectal bleeding or blood in stool
- ☐ Black colored stools
- ☐ Hemorrhoids
- ☐ Abdominal pain or heartburn
- ☐ Trouble swallowing

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Back pain
- ☐ Fractures

INTEGUMENTARY

- ☐ Rash or itching
- ☐ Abnormal hair loss
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge

MALE:

- ☐ Discharge from penis, sores on genitals
- ☐ Decrease in urine stream
- ☐ Dribbling
- ☐ Slow to start/stop urination
- ☐ Urination at night (more than 1x/night)
- ☐ Erectile dysfunction

FEMALE:

- ☐ Date of last menstrual period: _____
- ☐ Birth control issues/questions
- ☐ Pain with intercourse
- ☐ Vaginal discharge/itching
- ☐ Do you have hot flashes?
- ☐ Are you taking hormones?
- ☐ Do you take calcium?

EMOTIONAL/MENTAL HEALTH:

- ☐ Depression
- ☐ Anxiety
- ☐ Panic
- ☐ Thoughts of suicide
- ☐ Other: _____

OTHER:

- ☐ Tropical illness, travel outside the US
- ☐ Disability (any

Other issues/symptoms you want discuss with the medical provider:

*PROVIDERS ONLY: I have reviewed pages 6-8 of this patient's intake form.

Provider's Printed Name: _____

Provider's Signature: _____ Date: _____