Family Health Network of Central New York, Inc.
PATIENT INFORMATION

1. **Patient's Name**: _____ **Today's Date**: _____
2. **Patient's Social Security #:** _____ **Date of Birth:** _____
3. **Sex Assigned at Birth** ☐ Female ☐ Male
4. **Gender Identity:** ☐ Female ☐ Male ☐ Female to Male ☐ Male to Female
   ☐ Genderqueer neither exclusively male nor female
   ☐ Additional gender category or other, please specify _____
   ☐ Choose not to disclose
5. **Sexual Orientation:** ☐ Straight (not lesbian or gay) ☐ Lesbian or gay ☐ Bisexual ☐ Something else
   ☐ Don't know ☐ Choose not to disclose ☐ Other, please specify_____
6. **Primary Language:** ☐ English ☐ Spanish ☐ Other _____
7. **Email Address**: _____
8. a) If patient is a minor, are you the legal parent (biological or adoptive) or legal guardian for the minor?
   ☐ Yes ☐ No
   b) If NO, do you have authority to sign for services for the minor? ☐ Yes ☐ No
   c) If YES, and not the biological parent, please supply a copy of the legal paperwork granting custody or right to sign for the minor OR present a "Consent for Treatment of a Minor" form signed by the parent/legally designated guardian.
   d) If no, who has legal authority? _____
9. Emergency Contact: Name: _____ Phone Number: _____
   Relationship to Patient: _____

Because Family Health Network of CNY is federally funded, we are required to collect the information asked in questions 10 through 32. This information is used for statistics only, without anyone's name attached to it and will remain confidential. Reporting these statistics to the federal government enables Family Health Network of CNY to continue to receive funding for the services we provide. Thank you for your cooperation.

10 **Ethnicity**: ☐ Not Hispanic/Latino/a ☐ Mexican, Mexican/American, Chicano/Chicana
☐ Puerto Rican ☐ Cuban
☐ Another Hispanic or Latino/a ☐ Choose Not to Report

11. **Race**: (Check all that apply)
☐ White ☐ Black or African-American

Asian
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Other Asian

Pacific Islander
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian/Chamorro
☐ Samoan

☐ American Indian or Alaska Native ☐ Refused to report

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Patient's Name: _____

12. **Are you a migrant worker or member of the family?** ☐ Yes ☐ No

13. **Are you a seasonal agriculture worker or member of the family?** ☐ Yes ☐ No

14. **Do you live in Public/Section 8 Housing?** ☐ Yes ☐ No

15. **Are you homeless?** ☐ Yes ☐ No

16. **Are you a Veteran?** ☐ Yes ☐ No

17. **Please place a check mark under the amount(s) of your annual household income range**.

$0,000 - $11,490	$11,491 - $15,510	$15,511 - $19,530	$19,531 - $23,550	$23,551 - $27,570	$27,571 - $31,590	$31,591 - $35,610	$35,611 - $39,630	$39,631 - $43,650	$43,651 - $47,670	$47,671 - $51,690	$51,691 - $55,710	$55,711 – over
____	____	____	____	____	____	____	____	____	____	____	____	____

18. **Number of people in your household**: _____ ☐ Patient refused to provide income information_____
Pt. initials

19. **What is your housing situation today?**
☐ I have housing
☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐ I choose not to answer this question

20. Are you worried about losing your housing?
☐ Yes ☐ No ☐ I choose not to answer this question

21. What address do you live at? _____

22. What is the highest level of school that you have finished?
☐ Less than high school degree ☐ High school diploma or GED ☐ More than high school
☐ College degree _____
☐ I choose not to answer this question

23. What is your current work situation?
☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work
☐ Otherwise unemployed but not seeking work (ex: student, retired, disable, unpaid primary care giver. Please write: _____
☐ I choose not to answer this question

24. What is your main insurance?
☐ None/uninsured ☐ Medicaid ☐ CHIP Medicaid ☐ Medicare
☐ Other public insurance (not CHIP) ☐ Other public insurance (CHIP) ☐ Private insurance

25. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.
☐ Yes ☐ No **Food**
☐ Yes ☐ No **Child Care**
☐ Yes ☐ No **Phone**
☐ Yes ☐ No **Legal Services**
☐ Yes ☐ No **Clothing**
☐ Yes ☐ No **Medicine or Any Health Care** (Medical, Dental, Mental Health, Vision)
☐ Yes ☐ No **Other** Please write: _____
☐ I choose not to answer this question
☐ Yes ☐ No **Utilities**

Patient's Name: _____

26. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.
    - ☐ Yes, it has kept me from medical appointments; or
    - ☐ Yes, it has kept me from non-medical appointments, meetings, appointments, or work, or from getting things that I need
    - ☐ No
    - ☐ I choose not to answer this question

27. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings).
    - ☐ Less than once ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5 or more times a week
    - ☐ I choose not to answer this question

28. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
    - ☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much
    - ☐ I choose not to answer this question

Optional additional questions. If you choose not to answer questions 29-32, please proceed to the boxes underneath question 30.

29. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?
    - ☐ Yes ☐ No ☐ I choose not to answer this question

30. Are you a refugee?
    - ☐ Yes ☐ No ☐ I choose not to answer this question

31. Do you feel physically and emotionally unsafe where you currently live? **If yes, please notify your provider during today's visit.**
    - ☐ Yes ☐ No ☐ I choose not to answer this question

32. In the past year, have you been afraid of your partner or ex-partner?
    - ☐ Yes ☐ No ☐ I have not had a partner in the past year.
    - ☐ I choose not to answer this question

☐ Family Health Network has permission to contact me and/or leave a message, including automated messages, and text/SMS messages, at phone number _____ for:

☐ Appointment messages ☐ Need to Contact Health Center ☐ Test Results ☐ Billing/Collections Information

Preferred method of contact ☐ Phone call ☐ Text

☐ Family Health Network **does not** have permission to contact me by phone or text.

I understand that if I request the information to be sent by text, it will not be encrypted and there is a risk that my Protected Health Information could be read or accessed by a third party.

If you do not have health insurance coverage, you may be eligible for health insurance through one of our programs. If eligible, the program in your county may pay for office visits, hospitalization, prescription, vision, and dental care. Family Health Network will be happy to assist you in receiving more information and/or applying for this program.

Would you like to be contacted by one of our enrollers? Yes or No (circle one)

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Patient's Name: _____

IMPORTANT
PLEASE READ BELOW and SIGN

By signing this form, you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat HIV/AIDS and medicines used to treat mental health conditions such as depression. This information may become part of your medical record based on your provider's discretion.

Signature _____

IMPORTANT
PLEASE READ BELOW and SIGN

I authorize the release of any medical information necessary to process billing to my designated health insurance company(ies) and make payment to Family Health Network of CNY. If your insurance company(ies) pays you directly for the services provided by Family Health Network of CNY, it is your responsibility to forward the payment to Family Health Network of CNY. Failure to forward the payment is insurance fraud. If an account is forwarded to a collection agency, you will be responsible for all the balances due, collection fees, and/or legal fees. My signature below indicates my understanding and acceptance of the above release of information and payment policies as stated above.

Signature_____ **Date**_____ **Witness** _____

33. **Advanced Directives**: Given By: _____ Date Given: _____ Yes ☐ No ☐ On file ☐

Patient Signature, if refused: _____

34. **Patient Rights and Responsibilities**: Given By: _____ Date Given: _____

Current patient – already provided ☐

35. **Sliding Fee Scale**: Offered By: _____ Date Offered: _____ Accepted - Yes ☐ No ☐

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