AARC
Health Equity Clinic

New Patient Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

You will notice that we ask questions about race and ethnic group background. We do this so we can provide a more cultural appropriate treatment and make sure everyone gets the highest quality of care.

While this clinic recognizes differences in gender identities, sex and sexual orientation; many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Please print all responses: **Date: _____**

Legal Name: _____ Social Security Number: _____ DOB: _____

Preferred Name: _____ Preferred Pronoun: He/him, She/her, other_____

Address: _____

Phone Number: _____ Work Number: _____ Cell Number: _____
(ok to leave message: **Y N**) (ok to leave message: **Y N**) (ok to leave message: **Y N**)

Email Address: _____
(ok to contact by email: **Y N**)

Sex/Gender: Male, Female, Intersex, Transgender Female-to-Male or Male-to-Female, Questioning **(circle one)**

Race: (e.g.: African-American, Latino, Asian, etc): _____

Ethnicity: (e.g.: Mexican, Hawaiian, Irish, etc): _____

Education Level: _____ Occupation: _____

Do you work outside the home? _____(please specify in describing your work)

Number of hours Worked per Week: _____ Religious/Spiritual Beliefs:_____

Relationship/Marital Status: _____ (Partnered, living together, Divorced)

Name of your Partner or Spouse: _____

Do you live with anyone? _____ Number of children: _____ Ages: _____

_____

How did you hear about us? Advertisment, Billboard, Goggle, Word of mouth, Social Media, other_____

Language spoken most often: _____ Do you need an interpreter? ◯ Yes ◯ No

The confidentiality of your health information is protected in accordance with Federal Protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPPA).

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INSURANCE INFORMATION

Primary Insurance Type: _____

ID: _____ Subscriber: _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary Insurance Type: _____

ID: _____ Subscriber: _____

Insurance Address: _____

Insurance Phone Number: _____

I have presented evidence of valid insurance coverage, as of this date below to AARC Health Equity Clinic. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time of services are rendered.

I, _____, hereby assign all medical provider benefits payable (i.e. Payor: Private Insurance company, Medicare, Medicaid, etc.) and related rights existing under the Payor coverage that I have identified in connection with the services provided directly to the AARC Health Equity Clinic and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS, for payment purposes. I understand that any payment received by the AARC Health Equity Clinic for this period may be applied to any unpaid bill(s) for which I am liable.

I understand that different Payor's have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary. **I understand** that it is my obligation to know my Payor's requirements and ensure that they have been fulfilled. **I understand that AARC is a Payor of last resort and I am responsible for any unpaid charges.**

I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the AARC Health Equity Clinic the full balance that is not reimbursed by my medical provider benefits (certain regulations and exceptions apply for Medicare Beneficiaries).

Additionally, if the AARC Health Equity Clinic elects to pursue an appeal of any denials by my Payor of the payment for services rendered, this Statement constitutes written consent that the Facility and/or its agents have the authority to pursue any and all appeals, including arbitration on my behalf. This financial responsibility is hereby affirmed and acknowledged by my signature below.

I understand that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts and paid in a timely manner. **I understand that I am obligated to pay all co-payments, deductibles and any non-covered out-of network/reduced benefits at the time services are rendered.** I understand that it is my duty to inquire about financial assistance and/or payment plan options available to me.

_____ _____

Patient Signature **Date**

AARC Health Equity Clinic

MEDICAL HISTORY

Please check all that apply:

- ○ Emphysema
- ○ Tuberculosis
- ○ Pneumonia
- ○ Bronchitis
- ○ Asthma
- ○ Allergies
- ○ Heart Disease
- ○ Stroke
- ○ High Blood Pressure
- ○ Elevated Cholesterol
- ○ Diabetes
- ○ Venous Thrombosis
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ Cirrhosis
- ○ Anemia
- ○ Thyroid Trouble
- ○ Gallbladder Disease
- ○ Ulcers
- ○ Frequent urination / Tract Infections
- ○ Sexually Transmitted Infections
- ○ Prostate Trouble
- ○ Cancer
- ○ Arthritis
- ○ Osteoporosis
- ○ Fractures
- ○ Migraines
- ○ Depression
- ○ Anxiety or Panic Disorder
- ○ Post-traumatic Stress Disorder
- ○ Alcohol or Substance Use Problem
- ○ Other: _____

SYSTEMS REVIEW

General:

- ○ Recent weight loss
- ○ Recent weight gain
- ○ Fatigue
- ○ Fever
- ○ Changes in appetite
- ○ Night sweats

Skin:

- ○ Rashes
- ○ Lumps
- ○ Itching
- ○ Dryness
- ○ Color changes
- ○ Hair and Nail changes

Head:

- ○ Headaches
- ○ Head Injuries
- ○ Dizziness

Eyes: Date of Last Eye Exam: _____

- ○ Glasses
- ○ Contacts
- ○ Eye pain
- ○ Double vision
- ○ Redness
- ○ Glaucoma
- ○ Cataracts
- ○ Other: _____

Nose:

- ○ Frequent Colds
- ○ Nasal stuffiness
- ○ Hay fever
- ○ Nosebleeds
- ○ Sinus trouble
- ○ Allergies: dust/animal/seasonal

Ears:

- ○ Hearing loss
- ○ Ear pain
- ○ Ringing in the ear

Mouth and Throat: Date of last Dental Exam: _____

- ○ Bleeding gums
- ○ Frequent sore throats
- ○ Hoarseness