

Date of Birth: _____ Gender assigned at birth: **M** **F**

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip code _____

Social Security # _____ / _____ / _____ Marital Status: (circle) Married Single Widowed Divorced Separated

Home Phone # _____ / _____ / _____ Cell Phone # _____ / _____ / _____ Family Physician _____

Patient's email: _____ If none, leave blank.

Sexual orientation: ☐ Lesbian, gay/homosexual ☐ Straight/heterosexual ☐ Bisexual ☐ Don't know

Gender Identity: ☐ Identify as Male ☐ Identify as Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Non-confirming Pronouns used: ☐ he/him ☐ she/her ☐ they/them

Race: ☐ White ☐ Black/ African American ☐ American Indian/ Alaska Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ Bi-Racial

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic/ Latino Preferred language: (circle) English Spanish Other _____

Guardian / Responsible Party _____ / _____ / _____ Phone: _____ / _____ / _____
Last Name First Name M.I. Date of Birth

Address (if different than above) _____
Street City State Zip code

Primary Insurance _____ Policyholder Name _____ D.O.B. _____

Employer _____ Patient's Relationship to Policyholder (check one) Self ☐ Spouse ☐ Dependent ☐

Secondary Insurance _____ Policyholder Name _____ D.O.B. _____

Employer _____ Patient's Relationship to Policyholder (check one) Self ☐ Spouse ☐ Dependent ☐

EMERGENCY CONTACT: Please give the name and phone number of a responsible person that you give permission for our office to give test results, or other medical information in case of emergency.

Name _____ Relationship _____ Phone # _____

DRUG ALLERGIES: Yes No **LIST MEDICATION & TYPE OF ALLERGIC REACTION :**

CURRENT MEDICATIONS: DOSAGE AND TIMES PER DAY: I give permission to obtain my medication history, benefits, and formulary information from my pharmacy on file. Yes No

FAMILY MEDICAL HISTORY: Do any relatives have any of the following? Circle and indicate which family member (Mother, Father, Sister, Brother, Aunt, or Uncle)

Heart Disease _____ Stroke _____ Asthma _____ COPD _____
High blood pressure _____ Diabetes _____ Cancer _____ Bleeding/clotting disorder _____

SOCIAL HISTORY: Do you use tobacco products? YES NO How much per day? _____
Do you drink alcohol? YES NO How many drinks per week? _____

PLEASE LIST ANY SURGERIES: _____

PATIENTS PAST MEDICAL HISTORY: Does the patient have any of the following illnesses? Please circle

Diabetes	Heart Disease	Heart Murmur	High blood pressure	Heart Attack	Asthma	Tuberculosis	Stroke
COPD	Kidney Stones	Renal failure	Seizures	Arthritis	Ulcers	Acid reflux	Hepatitis
Stroke	Irritable bowel	Thyroid problems	Seasonal allergies	Bleeding/clotting disorder	Cancer	_____	
Last menstrual period _____		Other _____					

Received Pneumonia Vaccine: Year _____ Received Current Flu Vaccine: () YES () NO

I am authorizing treatment for the above patient as deemed necessary by the attending physician. I authorize the release of any medical or other information necessary to process claims on my behalf & for my insurance benefits (including authorized Medicare benefits, if applicable) be paid directly to Health Alliance for any services furnished. I understand that I am responsible for all co pays, deductibles, and co insurance. Furthermore, if I am not eligible for insurance, I am responsible for full payment of services rendered. I acknowledge that I have been notified of the revised Notice of Privacy Practices of Alliance Citizens Health Association effective 6/12/18, which sets forth the ways in which my protected health information may be used or disclosed by ACHA, and outlines my rights with respect to such information. I have been provided the opportunity to request a paper copy of this notice as well as information on how to view the notice electronically on the website at www.achosp.org.

Signature: _____ Date: _____

Relationship if not signed by patient