PATIENT DEMOGRAPHICS FORM

Patient Name ____ **Date of Birth**________________
Last First M.

Sex: Female / Male **E-Mail Address**___________________________________

Primary Insurance	**Secondary Insurance**
Policy Holder Name	**Policy Holder Name**
Policy Holder DOB	**Policy Holder DOB**
Employer ID #	**Employer ID #**

LIST BELOW ALL FAMILY MEMBERS LIVING IN HOUSEHOLD

________________________ ____________________ ___________________________
________________________ _________________________ ___________________________
________________________ _________________________ ___________________________

Financial Information for Applying or Refusing the Sliding Fee Program

Income Information for:

Household Income ______________________

Other Income___________________________

Total Income___________________________

Total Dependents in Household____________

Proof of income source: Pay stubs, child support Unemployment, disability, social security, etc.

- I am refusing the sliding fee discount.
- Under penalties of perjury, I certify that I have no income of any kind
- I am applying for Sliding Fee and will provide proof of income

Proof of income must be provided for the year you wish to receive a sliding fee discount

For Office Personnel Use Only:

Sliding Fee %___________________________ Sliding Fee

I certify that as of this date, the above information is correct to the best of my knowledge. I authorize payment of all insurance policy benefits, to be paid directly to Hopewell Health Centers, Inc. Furthermore, I authorize Hopewell Health Centers, Inc. to release all medical information to any physician, agency (ies). I also, understand that failure to notify Hopewell Health Centers, Inc. of any addition or corrections will terminate my eligibility for the sliding fee, should I qualify. Any false statement will jeopardize the discount and result in full payment of my account.

Patient/Guarantor Signature:____

Consent for Evaluation and Treatment

Hopewell Health Centers (HHC) is dedicated to providing primary care, dental and mental health services to residents of our communities. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. HHC patients may be referred to providers from other health care specialties within the HHC treatment team. Patient evaluation and treatment may include, but not limited to imaging, laboratory or psychological testing.
HHC will use and share patient information for the treatment, payment and continuity of care, otherwise information about the patient will NOT be given to anyone outside HHC, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission. I am 18 years of age or older, I can consent for all health services; otherwise my parent or legal guardian will need to consent for services, except for certain circumstances.
I hereby agree to the evaluation and treatment of my child __________________ DOB____________, including any testing or procedures that HHC professional staff deem necessary.

Patient/Guardian's Signature_______________________________ Printed Name__________________ Date____________________

HHC Employee Signature________________________________ Printed Name__________________Date____________

HOPEWELL HEALTH CENTERS- HISTORY FORM

Patient Name:______________________________ DOB:____________________ Pharmacy:______________________
Address:____
Parent/Guardian Contact:____ Phone: (   ) ______-_____________
Emergency Contact:____ Phone: (   ) ______- ____________
[Optional] Race: [ ] White, [ ] Black, [ ] Native American, [ ] Hispanic, [ ] Asian, Other:__________________________
[Optional} First Language: [ ] English, [ ] Spanish, Other:__________________________

<u>Medical History</u>
Check all that apply:

Asthma	Cancer	High Blood Pressure	If any apply, please explain below:
RSV/Pneumonia	Epilepsy/Seizures	Diabetes	
ADD/ADHD	Mental Illness	Kidney Disease/Infection	
Heart Murmur/Disease	Broken Bones	Concussion	

Family Medcial History: Example- (Diabetes, High Blood Pressure, Asthma, etc)

Mother:__________________________ Father:________________________ Siblings:___________________________

Past Overnight Hospitalizations/Surgeries, Reasons and Dates:

1.____

2.____

3.____

Medication Allergies

1. ______________________________

2.______________________________

3.______________________________

Current Medications

Medication Name	Dosage	Directions

HOPEWELL HEALTH CENTERS- HIPAA FORM

I, ______________________________, _______________, understand that as part of my child's health care, this office keeps health
(Parent/Guardian) (DOB)
records, describing my child's health history, a list of symptoms, or medical problems, details on the doctor's examination, results from tests, diagnosis, treatment and any future plans for treatment. I understand that this record serves as:

- A way for the health care provider to plan care and treatment
- A way for all the health professionals involved in the care of my child to have the same information
- Information that can be given to my insurance company or the agency paying for my child's care so they can make sure they received the services that Hopewell Health Centers, Inc. billed for,
- And as a way for Hopewell Health Centers, Inc. to make sure they are providing my child with the best care possible.

I have also been given a copy of the *Notice of Information Privacy Practices* that tells more about the items listed above, I understand that if I have any questions either now or in the future about this information, I can talk to a staff member.

Parent/Guardian Signature:____ Date:___________________

Employee Signature:____ Date:___________________