GENERATIONS FAMILY HEALTH CENTER, INC. 2023-24 SBHC PATIENT INTAKE FORM

SCHOOL:
GRADE:

Email address: ____

First: ______________________________**Middle**: _______ **Last:**____________________________________

Other name you are known by:____________________________________ **Please c one: Sr, Jr, II, III**

DOB: ____________ **SSN**: _______________ **Primary Language**: ________________

Address: ___________________________________ **City:** ______________ **State**: CT **Zip**: __________

If patient is under 18, or is an adult with a conservator, please complete the following:

Parent Name: _______________________________________ **Phone:** _______________________________

Parent Name: _______________________________________ **Phone:** _______________________________

Guardian/Conservator Name: _________________________________ **Phone:** ________________________

Relationship to Patient: ____

*** *If the patient has a legal guardian or conservator, please discuss this information with our staff. Generations must be given the documents regarding the guardian or conservator as proof to consent to care and billing.***

RACE – check all that apply		CONTACT INFORMATION
Asian		Home phone:
Black/African American		Cell phone:
Native American/Alaskan Native		Work phone:
Native Hawaiian		Email address:
Pacific Islander		How do you want to receive appointment messages? Call: ______ Text: ______ Email: ______ All of these ______
White/Caucasian		

If there is an emergency and we can't reach you, may we call someone to have you call us? Yes ___No __

If yes, name of Emergency Contact**:** ________________________________ Phone: ____________________

What is your relationship to this Emergency Contact? ____

Is there someone who you wish to allow us to talk to about your healthcare on an ongoing basis?

Yes _____ No _____ If yes, name: ______________________________ ******If yes, please sign a consent form.***

Are you of Hispanic origin? (Choose one)	Yes	No					
Gender at Birth: (Choose one)	Male	Female					
Current Gender Identity: (Choose one)	Male	Female	Transgender Male (Female to Male)	Transgender Female (Male to Female)	Other	Don't know	No answer
Sexual Orientation: (Choose one)	Lesbian or Gay		Straight	Bisexual	Other	Don't know	No answer
Housing Status: (Choose one)	Rent or Own		Shelter	Street	Temporarily staying with someone		
	Some type of supportive or transitional housing program						

Do you have a Primary Care Provider outside of Generations? Yes ______ No ______

If yes, Provider Name: __________________________ Practice Name: ______________________________

Primary Pharmacy Name: ___________________________________ Town: ____________________________

Secondary Pharmacy Name: _________________________________ Town: ____________________________

Staff Initials: _______________

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INSURANCE

We require that all insurance information be provided, including a copy of your insurance card. If you do not provide us with your insurance card and accurate information as requested below, you may be financially responsible for any service provided. Please provide ALL Insurance information regardless of the services rendered.

Medical Coverage	Primary Insurance	Secondary Insurance	Tertiary Insurance
Plan Name:			
Insurance ID:			
Group #:			
Subscriber Name:			
Subscriber's DOB			
Subscriber's Employer			
Relationship to insured			

Dental Coverage	Primary Insurance	Secondary Insurance	Tertiary Insurance
Plan Name:			
Insurance ID:			
Group #:			
Subscriber Name:			
Subscriber's DOB			
Subscriber's Employer			
Relationship to insured			

Behavioral Coverage	Primary Insurance	Secondary Insurance	Tertiary Insurance
Plan Name:			
Insurance ID:			
Group #:			
Subscriber Name:			
Subscriber's DOB			
Subscriber's Employer			
Relationship to insured			

Please circle applicable answers:

Marital Status	Single	Married	Divorced Widowed	Legally Separated
Employment status	Employed	Self-employed	Student	Unemployed
	Disabled	Retired		
If your insurance is through an employer or school, please list the company or school name below:				
				☐ Employer ☐ School

How did you hear of Generations? Check one please:

Another patient	☐	Radio	☐	Facebook	☐	Hospital	☐
Family/Friend	☐	Print Ad	☐	Another Provider	☐	Service Agency	☐
Insurance	☐	Website	☐	School	☐	GFHC Employee	☐
Television	☐	Other:	☐	If other, please explain:			

Patient Name: ____ Staff Initials: _________________

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ADDITIONAL INFORMATION

(We ask this information so we can better help you or your family with services.)

Are you a Veteran discharged from the U.S. Military? Yes _____ No _______

Do you work on a farm? Yes ______ No ______ **If yes, farm name:** ____

If yes, are you a "Seasonal Worker"? Yes ____ No ______ Are you here on a work visa? Yes ____ No _____

Are you here as a refugee from another country? Yes ____ No ____ **If yes, name of country:** ________________________________

*** *If you answered yes to any of the questions above, we may be able to provide you with some assistance. Do you wish to hear more?*** *Yes _____ No ______*

CONSENT FOR TREATMENT AND BILLING

Please read the information below and sign/date your consent for treatment at SBHC to occur. We will always have contact with you prior to your child being seen for any service, but this written permission will assist the process when your child needs care. Dental care is provided by a Registered Dental Hygienist, and behavioral health care is provided by a licensed therapist (LCSW/LMFT/LPC/LMSW).

I give my permission to provide the following care for my child: (Please check each you are consenting to)

_____DENTAL **_____BEHAVIORAL HEALTH**

1. I certify that the above information is the truth to the best of my knowledge.
2. I give consent to exam and treatment, by all qualified personnel at Generations, for the above named individual.
3. I hereby authorize Generations Family Health Center, Inc. to release to my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to Generations Family Health Center, Inc.
4. I understand I am financially responsible for any balance not covered by my insurance carrier.
5. I understand that I am responsible for any balance of payment and co-payments and they are to be paid at the time of service. (*We reserve the right to refer your account to a collection agency in certain circumstances)*

____ Date: ______________________

Signature of Patient (or Responsible Party if Patient is under 18 years old)