

SCHOOL:
GRADE:

Email address: _____

First: _____ Middle: _____ Last: _____

Other name you are known by: _____ Please choose 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?	
White/Caucasian		Call: _____ Text: _____ Email: _____ All of these _____	

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: _____

GENERATIONS FAMILY HEALTH CENTER, INC. 2025-26 SBHC PATIENT INTAKE FORM

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.

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

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

<u>Behavioral Coverage</u>	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:				
<input type="checkbox"/> Employer <input type="checkbox"/> School				

How did you hear of Generations? Check one please:

Another patient	<input type="checkbox"/>	Radio	<input type="checkbox"/>	Facebook	<input type="checkbox"/>	Hospital	<input type="checkbox"/>
Family/Friend	<input type="checkbox"/>	Print Ad	<input type="checkbox"/>	Another Provider	<input type="checkbox"/>	Service Agency	<input type="checkbox"/>
Insurance	<input type="checkbox"/>	Website	<input type="checkbox"/>	School	<input type="checkbox"/>	GFHC Employee	<input type="checkbox"/>
Television	<input type="checkbox"/>	Other:	<input type="checkbox"/>	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)

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

Date: _____