NOAH
Neighborhood Outreach Access to Health

Demographic Form

Patient Information

Patient Name:	
Preferred Name:	Date of birth:
Patient Sex: ☐ Male ☐ Female ☐ Unknown	SSN:
If under age 18-Parents(s)/Guardian(s) name(s):	
Relationship status: ☐ Divorced ☐ Legally seperated ☐ Married ☐ Significant other ☐ Single ☐ Unknown ☐ Widowed ☐ Other	
Home Address:	
City, State, Zip:	Cell phone number: ( )
Work phone: ( )	Home phone: ( )
Email Address:	
Preferred method of contact: ☐ Mail ☐ Phone ☐ E-mail ☐ MyChart	
Employment status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Disabled ☐ Retired ☐ Student ☐ Active Military ☐ Not employed	
Employer:	Occupation:

Emergency Contact Information

Name:	Cell Phone:
Relationship:	Home phone:

Insurance Information

Primary Insurance:	Subscriber Name:	
Patient Relationship to subscriber:	Subscriber DOB:	Subscriber Sex: ☐ Male ☐ Female ☐ Unknown
Secondary Insurance (If applicable):	Subscriber Name:	
Patient Relationship to subscriber:	Subscriber DOB:	Subscriber Sex: ☐ Male ☐ Female ☐ Unknown

NO SHOW POLICY
It is important for you to keep all of your appointments. Please contact us as soon as possible if you cannot make it to your appointment. We ask for at least a 24-hour notice if you are going to cancel or change your appointment. Three (3) missed appointments within six (6) months will result in a same-day only appointment status. Continued no-shows may result in dismissal from NOAH.

By signing below, I state that the information on this form is true and correct to the best of my knowledge. I also have been informed and understand the NOAH No Show Policy, and I acknowledge and give consent to receiving a survey related to my care via email and/or text.

Patient/Guardian Signature

Date

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UDS FORM

Name: ________________________________ Date of birth: ____________________

As a community healthcare center, we are required to ask the following questions. This information is needed to receive additional funding to better serve you and all members of our community.

1. How did you hear about NOAH?

- ☐ Existing patient
- ☐ NOAH website
- ☐ Physician referral
- ☐ Online directory
- ☐ Insurance company
- ☐ Postcard
- ☐ Hospital2NOAH
- ☐ Event
- ☐ Social media
- ☐ Family or friend
- ☐ Flyer or brochure
- ☐ Other ________________

2. How many people are in your household?________________________________

3. What is the combined **monthly** income?

- ☐ Under $500/month
- ☐ $501 - $1,000/month
- ☐ $1,001 - $2,500/month
- ☐ $2,501 - $4,000/month
- ☐ $4,001 - $5,500/month
- ☐ $5,551 - $7,000/month
- ☐ $7,001 - $8,500/month
- ☐ $8,501+/month

4. What best describes your current housing situation:

CHECK BOX	HOUSING SITUATION	**THIS COLUMN FOR OFFICE USE ONLY:** (enter this category in Epic/UDS screen)
☐	I rent or own my home? I live with my parents/legal guardian. I live in a home with roommates; we all share the rent. I live in a college/university dorm.	Not homeless
☐	I temporarily live with someone else; ex. Couch-Surfing	Doubling up
☐	I stay in a shelter, which provides meals and a place to sleep; I cannot stay here long. Ex. Homeless shelter	Shelter
☐	I live in a temporary housing to help me find my own home. I can stay here up to two years. Ex. Drug treatment housing	Transitional Housing
☐	I live in a residence paid by rental assistance.	Permanent Supportive Housing
☐	I currently reside in the street, my car, encampment.	Street
☐	Did you experience homelessness in the past year and your housing situation is none of the above choices?	Other

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5. Please select the race that you most identify with:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Caucasian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ More than one race
- ☐ Other
- ☐ Do not wish to identify

6. Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

7. Are you a farm worker?

- ☐ Yes
- ☐ No

8. Sexual Orientation

- ☐ Straight (not lesbian or gay)
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Other
- ☐ Do not know
- ☐ Do not wish to identify

9. Gender Identity

- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Other gender
- ☐ Do not wish to identify

Health History Form

Full Legal Name: ______________________________ Date of Birth: ______________

Preferred Name: ______________________________

Allergies: ______________________________

Pharmacy Name & Cross Streets: ______________________________ Phone: ______________

Medication: Please list any medications, vitamins or over the counter medicine you are currently taking.

Name of Medication	Dose	How often do you take it?	What is this medication for?

Please mark any appropriate medical conditions/problems that you have been treated for:

❑ ADD/ADHD	❑ Cancer	❑ GERD/ Acid Reflux	❑ Migraines
❑ Allergic Rhinitis	❑ Cataracts	❑ Glaucoma	❑ Heart Attack (MI)
❑ Anemia	❑ Heart Failure (CHF)	❑ Heart Murmur	❑ Stomach Ulcers
❑ Anxiety	❑ COPD	❑ HIV/AIDS	❑ Seizures
❑ Asthma	❑ Coronary Artery Disease	❑ Hyperlipidemia	❑ Sexually Transmitted Disease (STD)
❑ Arthritis	❑ Depression	❑ Hypertension	❑ Stroke
❑ Bipolar Disorder	❑ Diabetes Mellitus Type 1	❑ Hyperthyroidism	❑ Substance/Drug Abuse
❑ Blood Clots	❑ Diabetes Mellitus Type 2	❑ Hypothyroidism	❑ Valley Fever
❑ Blood Transfusion	❑ Emphysema	❑ Kidney Disease	❑ Other:

Your Birth History (If known):

Delivery Method: ______________ Gestational Age: Full Term ❑ Pre-mature ❑

Birth Length: ______________ Birth Weight: ______________ Birth Head Circumference: ________

Surgical History: Please mark any surgeries that you have had.

❑ Appendix removal	❑ Colon surgery	❑ Eye surgery	❑ Joint replacement	❑ Tonsils removed
❑ Breast Implants	❑ Heart stent	❑ Surgery for a broken bone	❑ Spine surgery	❑ Tubal Ligation
❑ Heart Bypass (CABG)	❑ Cosmetic Surgery	❑ Hernia Repair	❑ Thyroid surgery	❑ Heart valve replacement
❑ Gallbladder removal (Cholecystectomy)	❑ C-Section	❑ Hysterectomy	❑ Other:	❑ Other:

Family History:	High Blood Pressure	Cancer (Type)	Diabetes	Migraines	Stroke	Thyroid Disease	COPD/ Emphysema	Heart Disease	Other
Mother									
Father									
Siblings									
Children									

Have you ever smoked?

❑ Yes
❑No

What is your current smoking status?

❑Never Smoked
❑Current every day smoker
❑Current some day smoker
❑Former Smoker

What year did you start smoking? ___________

How many packs per day did/do you smoke? ___________

What year did you quit smoking? ___________

Type:
❑Cigarettes
❑Pipe
❑ Cigars
❑ Chew/Snuff
❑E-cig/Vape with nicotine

Do you currently use Alcohol? ❑ Yes ❑ Not currently ❑ Never

How much do you drink per week?
______ Glasses of Wine
______ Cans of beer
______ Shots of liquor
______ Mixed drinks

How often do you have 6+ drinks in a day?
❑ Never
❑ Less than monthly
❑ Monthly
❑ Weekly
❑ Daily or almost daily

Do you use recreational drugs? ❑ Yes ❑No

If yes, type:___________

Marital Status: ❑Single ❑Married ❑Widowed ❑Legally separated ❑Divorced ❑Significant Other

Are you Sexually Active? ❑Yes ❑Not currently ❑Never

With: ❑Men ❑Women ❑Both

Do you use Birth Control/ protection/barrier?
❑ Yes
❑No

Type of birth control/ protection/barrier used? _________________

Communication Consent Form

Patient Name:____ Date of Birth:__________

At times, we will call, text, or email you with appointment reminders or leave general informational messages on your voicemail.

I give permission to NOAH to communicate messages regarding appointments, referrals, lab results, and other information pertaining to my care.

May we leave a message on your **home phone** regarding the treatments you have received at NOAH:

Medical Dental Behavioral Health

(Please circle all that apply)

Home phone number: ________________________________

May we leave a message on your **cell phone** regarding the treatments you have received at NOAH:

Medical Dental Behavioral Health

(Please circle all that apply)

Cell phone number: ________________________________

May we mail results or documents **to your home** regarding the treatments you have received at NOAH:

Medical Dental Behavioral Health

(Please circle all that apply)

I give permission to NOAH to discuss my personal health information with the following individuals:

Name	**Relationship to Patient**
______________________________	_________________________
______________________________	_________________________
______________________________	_________________________

Patient/ Responsible Party Print Name:_____________________________________

Patient/Responsible Party Signature:_______________________________________ Date:_________

Approved & Revised 06/04/2019