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 ______________

Neighborhood Outreach Access to Health

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

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Pediatric 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 currently taking.

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

Please mark any appropriate medical conditions/problems the child has been treated for:

❑ ADD/ADHD	❑ Depression	❑ Heart Murmur	❑ Sexually Transmitted Disease
❑ Allergic Rhinitis	❑ Developmental delay	❑ Jaundice	❑ Speech problems
❑ Anemia	❑ Ear infections	❑ Learning disabilities	❑ Strep throat (recurrent)
❑ Anxiety	❑ Eczema	❑ Obesity	❑ Urinary tract infections
❑ Asthma	❑ GERD/ Acid Reflux	❑ Pneumonia (recurrent)	❑ Vision Problems
❑ Cancer	❑ Headaches	❑ Scoliosis	❑ Other
❑ Diabetes	❑ Hearing loss	❑ Seizures	

Birth History

Delivery Method: Vaginal ❑ C-section ❑ Gestational Age: Full Term ❑ Pre-mature ❑ ____weeks

Hospital Born:____________________Length:__________Weight:______________Head Circumference:______________

Complications?____ NICU? ❑ Yes ❑No

Was baby exposed to any drugs or medications during pregnancy? ______________________________________

Surgical History: Please mark any surgeries the child has had.

❑ Adenoids removed	❑ Ear tubes	❑ Orchiopexy
❑ Appendectomy	❑ Heart surgery	❑ Tonsils removed
❑ Circumcision	❑ Hernia surgery	❑ Other:

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Family History: Please mark any diagnoses that family members have

Family History:	Heart attack (before 50)	High blood pressure	Mental illness	Birth defects	Cancer (Type)	Diabetes	Migraines	High choles terol	Allergies	Asthma	Hearing loss	Other
Mother												
Father												
Siblings												
Grand-parent												

Who does the child live with?

❑ Mom, name________________
❑ Dad, name_________________
❑ Siblings? (names)

❑ Grandparent
❑ Step-parent
❑ Other family member

If parents do not live together, is there:

❑ Joint custody
❑ Single custody

Please check if applicable to patient:

❑ Adopted child
❑ Foster child

Does anyone smoke in the home?

❑ Yes
❑No

Are there guns in the home?

❑ Yes
❑No

Where does your child attend school?

Do they receive any special therapies or attend special education classes?

For children 13 years and older:

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

Have you ever smoked?
❑ Yes
❑No

Do you use recreational drugs?
❑ Yes
❑No

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

With:
❑Men
❑Women
❑Both

Do you use Birth Control/ protection/barrier?
❑ Yes

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:_________

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Consent for Treatment without Parent or Guardian Present

Patient Name:_______________________________ DOB:______________________

I authorize and give permission to the following individual(s) that are adults to accompany my child for treatment and to make decisions for any necessary treatment. The person bringing the child in must remain with the child while the child is being seen. This permission will remain in effect until revoked by the parent or guardian.

Emergency contact number(s) for parent/guardian: ___________________________________

_________________________ _________________________ __________

Parent/Guardian Name (Printed) Parent/Guardian Signature Date

Name of individual	Relationship to child	Phone number

Office Use Only
ID verified by:
Date:

ID of Authorized Individual
If Passport is used, scan a copy into the chart

Approved & Reviewed 06/04/2019