NOAH
Neighborhood Outreach Access to Health

New Patient Registration

Patient Information

Please let us know if you need assistance completing this form.

Patient First and Last Name: _____

Parent/Guardian Name (if under 18): _____

Preferred Name: _____

Pronouns:

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Ze/hir/hirs
- ☐ Ey/em/eirs
- ☐ Xe/xem/xyrs
- ☐ Ve/vir/vis
- ☐ Other _____
- ☐ Patient's name
- ☐ Choose not to disclose

Date of Birth: _____

SSN: _____

Legal Sex:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ X
- ☐ Don't know
- ☐ Choose not to disclose

The following information will be saved in your electronic health record and helps our providers deliver personalized care. Please choose the option that best describes you. Currently our system allows only one selection.

Gender Identity:

- ☐ Female
- ☐ Male
- ☐ Non-binary/ genderqueer
- ☐ Questioning
- ☐ Transgender female
- ☐ Transgender male
- ☐ Two spirit
- ☐ Don't know
- ☐ Other _____
- ☐ Choose not to disclose

Sex Assigned at Birth:

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Don't know
- ☐ Not recorded at birth certificate
- ☐ Choose not to disclose

Sexual Orientation:

- ☐ Straight
- ☐ Bisexual
- ☐ Gay
- ☐ Lesbian
- ☐ Asexual
- ☐ Omnisexual
- ☐ Pansexual
- ☐ Queer
- ☐ Don't know
- ☐ Other _____
- ☐ Choose not to disclose

Home Address: _____

City, State, Zip: _____

- ☐ Permanent
- ☐ Temporary
- ☐ Confidential
- ☐ Choose not to disclose

Phone Number: (Cell) _____ **(Home):** _____ **(Work):** _____

Email Address: _____

Relationship Status:

- ☐ Divorced
- ☐ Domestic partner
- ☐ Legally separated
- ☐ Married
- ☐ Significant other
- ☐ Single
- ☐ Widowed
- ☐ Don't know
- ☐ Other _____
- ☐ Choose not to disclose

Race:

- ☐ White
- ☐ Alaska Native
- ☐ American Indian
- ☐ Black/African American
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ More than one race
- ☐ Pacific Islander
- ☐ Asian
- ☐ Caucasian
- ☐ Don't know
- ☐ Other
- ☐ Choose not to disclose

Ethnic Group:

- ☐ Hispanic or Latino/a
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Not Hispanic or Latino/a
- ☐ Puerto Rican
- ☐ Don't know
- ☐ Other
- ☐ Choose not to disclose

Ethnic Background: _____

Additional Patient Information

Employment Status:

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Not Employed
- ☐ Unemployed (retired)
- ☐ Unemployed due to disability
- ☐ Active military duty
- ☐ Seasonal
- ☐ Self-employed
- ☐ Student full-time
- ☐ Student part-time
- ☐ Don't know
- ☐ Other
- ☐ Choose not to disclose

Employer: _____

Occupation:_____

Preferred Language:_____

Need Intepreter:

☐ Yes ☐ No

Written Language: _____

Language Spoken: _____

Preferred Method(s) of Contact:

- ☐ Mail
- ☐ Phone
- ☐ Email
- ☐ MyChart

Additional Demographics

Are you a veteran or do you have a military status?

- ☐ Yes
- ☐ No

Emergency Contact Information

Name: _____ **Relationship:** _____

Cell phone: _____ **Home phone:** _____

Patient Insurance Information

Primary Insurance (if applicable):

_____

Subscriber Name:

_____

Patient Relationship to Subscriber:

_____

Subscriber Date of Birth:

_____

Subscriber Legal Sex:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ X
- ☐ Don't know

Secondary Insurance (if applicable):

_____

Subscriber Name:

_____

Patient Relationship to Subscriber:

_____

Subscriber Date of Birth:

_____

Subscriber Legal Sex:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ X
- ☐ Don't know

By signing below, I acknowledge the information on this form is true and correct to the best of my knowledge. I acknowledge and give consent to receiving a survey related to my care via email and/or text.

_____ _____

Patient or Parent/Guardian Signature **Date**

NOAH
Neighborhood Outreach Access to Health

Housing and Income

Patient Information

First and Last Name: _____ **Date of Birth:**_____

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

1.

CHECK BOX	HOUSING SITUATION
☐	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.
☐	I temporarily live with someone else (ex. couch-surfing).
☐	I stay in a shelter, which provides meals and a place to sleep; I cannot stay there long (ex. homeless shelter).
☐	I live in temporary housing to help me find my own home. I can stay here for up to two years (ex. drug treatment housing).
☐	I live in a residence paid by rental assistance/Section 8 (public housing).
☐	I currently reside in the street, my car, or encampment.
☐	I experienced homelessness in the past year and my housing situation is none of the above choices.
☐	I currently have a home but cannot afford to pay the rent or mortgage and/or I was told I will be evicted soon.
☐	I currently live in a hotel.

2. How many people currently live in your household?_____

3. What is the combined monthly income of everyone in your household?

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

4. Are you a migrant or seasonal worker?

☐ Migrant ☐ Seasonal ☐ Neither

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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?
_____

Neighborhood Outreach Access to Health

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