His Branches Health Services

Grace Family Medicine
340 Arnett Blvd., Rochester, NY 14619
Phone: (585) 235-2250 • Fax: (585) 235-0011
Web: www.gfm3.org

Joy Family Medicine
918 N Goodman St., Rochester, NY 14609
Phone: (585) 697-0004 • Fax: (585) 697-0046
Web: www.joymed.org

NEW PATIENT INFORMATION (PLEASE PRINT CLEARLY)

PATIENT INFORMATION

FIRST NAME _____ M.I. _____ LAST _____

Circle: MR MRS MS DR OTHER _____ Circle: SR JR III OTHER _____

NICKNAME OR NAME YOU PREFER _____ MAIDEN NAME _____

PRIMARY MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS: _____

DATE OF BIRTH ____/____/_____ SOCIAL SECURITY NUMBER _____/____/_____

PARENT OR LEGAL GUARDIAN (if under 18)
or PRIMARY CAREGIVER (if you require assistance with your daily living)

FIRST NAME _____ M.I. _____ LAST _____

PRIMARY MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIONSHIP _____

EMERGENCY CONTACT: RELATIONSHIP _____

FIRST NAME _____ M.I. _____ LAST _____

PRIMARY MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

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_____
Please Print Patient Name

DEMOGRAPHICS

Gender	Marital Status	Employment	Ethnicity	Language
☐Male	☐Single	☐Employed	☐Multiple Races	☐English
☐Female	☐Married	☐Unemployed	☐American Indian/Alaskan	☐Spanish
☐Tansgender	☐Widowed	☐Retired	☐Asian	☐French
F to M	☐Divorced	☐Student	☐White (Not Latino)	☐German
M to F		☐P/T Student	☐Declines to state	☐Italian
☐Genderqueer		☐Disabled	☐Latino (Black)	☐Creole
Neither exclusively male or female			☐Latino (Multiple Races)	☐Chinese
☐Additional Gender Category			☐Latino (Other)	☐Hebrew
☐Declined to specify			☐Latino (White)	☐Other
☐None				☐Sign

Sexual Orientation
☐Straight/Hetrosexual ☐Gay/Lesbian ☐Bisexual ☐Don't Know
☐Declined to specify ☐None ☐Something else, please describe

Race
☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ All other races ☐ Declined to Specify/Unknown

Optional: This information is used to determine eligibility for our sliding fee scale program. Please ask for more details.
FAMILY SIZE: _____ HOUSEHOLD INCOME: _____

PRIMARY INSURANCE INFORMATION

PLAN NAME_____ MEMBER NAME _____

MEMBER I.D. _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE INFORMATION

COMPANY_____ POLICY I.D. _____

POLICY HOLDER _____ EFFECTIVE DATE: _____

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: _____ DOB: _____

Medical Conditions:

Please list all major medical conditions, when they first started, and when they resolved, if appropriate, or check "None" if you have no ongoing conditions:

☐ None

	Condition or Diagnosis	*Date Started*	*Date Resolved*
1			
2			
3			
4			
5			
6			

(Please use the back of the page if you need more room)

Specialists involved in your care:

☐ None

	Specialist's Name	*Specialty*	*Condition*
1			
2			
3			
4			

(Please use the back of the page if you need more room)

Medications:

Please list all prescriptions and any over the counter medications or herbal supplements you are taking, or check "None" if you are not taking any medicines or supplements:

☐ None

	Name of Medication	*Dose, e.g. 20 mg*	*How Often, e.g. 3x/day*
1			
2			
3			
4			
5			
6			
7			
8			

(Please use the back of the page if you need more room)

Primary Pharmacy:

Name_____ Address_____ Phone Number_____

Allergies:

☐ None

	Medication, Food, or Substance	*Reaction*
1		
2		
3		
4		

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: _____ DOB: _____

Hospitalizations and Past Medical Conditions:

Please list all serious injuries, hospitalizations or surgeries including the approximate date or your age at the time, as best you can remember, or check "None" if appropriate:

☐ None

	Hospitalization, Surgery or Serious Injury	*Age or Date*
1		
2		
3		
4		

Family History:

Your Relatives	*Their Names*	*Birth Year*	*Year/Cause of Death*	*Medical Conditions?* *(Use Numbers listed below*)*
Father				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

** List of Conditions (use numbers in boxes above)*			
1	Heart Disease (CAD)	7	Colon cancer
2	Stroke (CVA)	8	Breast or Prostate cancer
3	Diabetes (DM)	9	Lung cancer
4	High blood pressure (HTN)	10	Emphysema (COPD)
5	High cholesterol (Chol)	11	Thyroid
6	Arthritis	12	Obesity
13	Other		

His Branches Health Services NEW PATIENT HISTORY FORM

Patient's Name: _____ DOB: _____

Nicotine Use:

Smoking Status:

☐ Never smoked ☐ Occasional smoker ☐ Everyday smoker ☐ Former smoker

If you were or are a smoker, what do you smoke?

☐ Cigarettes (#/day_____) ☐ Cigars (#/day_____) ☐ Pipe (#/day_____)

Other Sources of Nicotine:

☐ Snuff ☐ Chewing tobacco ☐ E-cigarettes ☐ Nicotine gum

Social History:

HABITS

Do you drink alcohol? Y N What? /How much? _____ Quit date?_____

Do you use drugs? Y N What? /How much? _____ Quit date?_____

Do you exercise? Y N How? _____ Days/week?_____ Minutes/day?_____

EDUCATION / EMPLOYMENT

Highest grade level completed (1 - 12) _____ Do you have a high school diploma or GED? _____

Have you completed any years of college? If so, how many? _____

Name of College/Degree:_____

☐Associates ☐Bachelors ☐Masters ☐Professional Degree

Work (circle one): Full-time Part-time Unemployed Disabled Year last worked_____

Employer:_____ Position:_____

Military Service (circle one): None Army Navy Air Force Marines Coast Guard Merchant Marine

Year of draft or enlistment:_____ Year of discharge:_____

What brings you into the office today? (What is your chief medical complaint?)

_____

_____

_____

_____

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CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name: _____ **Social Security Number:** _____

Date of Birth: _____

PLEASE RELEASE COPIES OF MY MEDICAL RECORDS
(Please provide complete Office/Clinical/Hospital Address plus Phone and Fax numbers)

FROM:
Prior Doctor Name: _____
Clinic Name: _____
Address: _____
_____
PHONE: _____ FAX: _____

TO:
☐ **Grace Family Medicine** or
☐ **Joy Family Medicine**
(contact information in letterhead)

Purpose of Release: _X_ Treatment ___ Legal ___ Insurance Coverage ___ Personal ___ Other_____
Use/Disclosure: ___ One Time Disclosure **OR** ___ Periodic Use

Information to be disclosed: (Bold items must be initialed for release)
_X_ All Records ___ Progress Notes ___ **Psychiatric Information** ___ Assessments ___ Medical Information
___ Treatment Plans ___ All Laboratory Results (including pathology and Pap results) ___ Immunizations
___ All Radiological Results ___ **HIV-related info** ___ **Alcohol/drug treatment information** __**Substance Use Disorder**
___ Other _____

Information may be released by: _X_ Fax _X_ Copy X__ Verbal Means ___ Other_____

By signing below, I understand that:
- I will still receive Healthcare treatment if my Doctor does not send my records to His Branches Health Services.
- I may cancel this authorization at any time, in writing to the address provided above. This cancellation will not apply to already released information.
- If the recipient is not a healthcare or medical insurance provider, covered by the privacy regulations, the information indicated above may be re-disclosed.
- Psychiatric and alcohol/drug treatment info is protected under Federal and State Regulations and cannot be disclosed without my written authorization.
- The release of HIV-related information requires additional authorization if not already indicated above.
- There may be a charge for the requested records.

_____
(Signed) Patient or Legal Representative

_____ Date: _____
(Please Print Name)

His Branches Health Services

Patient's Name: _____ DOB: _____

CONTROLLED SUBSTANCE PRESCRIPTION POLICY

It is the policy of His Branches Health Services providers not to prescribe highly addictive pain medications, including Narcotics or other similar Controlled Substances, to patients who are new to the practice.

Please review the following list and complete one of the two statements below, EITHER A. or B.

Opiate Pain Medications	Tranquilizers	Sedatives
Codeine (Tylenol #3/#4)	Alprazolam (Xanax)	Amobarbital (Amytol)
Fentanyl (Duragesic)	Benzodiazepines	Barbiturates
Hydrocodone (Vicodin, Lortabs)	Clorazepate (Tranxene)	Butobarbital
Hydromorphone (Dilaudid)	Chlordiazepoxied (Librium)	Eszopiclone (Lunesta)
Meperidine (Demerol)	Clonazepam (Klonopin)	Pentobarbitol (Nembutal)
Methadone	Diazepam (Valium)	Secobarbitol (Seconal)
Morphine	Flurazepam Dalmane)	Zolpidem (Ambien)
Oxycodone (Oxycontin, Percocet)	Lorazepam (Ativan)	Zaleplon (Sonata)
Oxymorphone (Opana)	Oxazepam (Serax)	
Suboxone	Temazepam (Restoril)	
Tramadol (Ultram)	Triazolam (Halcion)	

A. ATTESTATION STATEMENT: Controlled Substance Prescription Policy

I understand that it is the policy of His Branches Health Services providers not to prescribe highly addictive pain medications, including Narcotics or other similar Controlled Substances, to patients who are new to the practice.

By signing below, I attest that I am not currently taking nor will I be seeking prescription renewals for any of the medications on your list, or any others similar to them.

Signed: _____ Full Name (Print) _____

Date of Birth: _____ Today's Date: _____

OR

B. EXCEPTION REQUEST: I am taking a medication on your list and request consideration for an exception to your Prescription Policy for the following reasons:

Medication:
Why I believe my situation should have an exception: (use back of page if needed)