Foothills Health and Wellness Center

New/Update Patient Assessment

Name: _____ Date: _____

Address: _____

Phone: _____ **SS#:** _____ **Date of Birth:** _____

Zip Code: _____ **Tobacco Use:** Yes / No **Are you a Migrant Farm Worker:** Yes/No

If You are a Migrant Farm Worker Please Circle Type: Seasonal Migrant Not a Farm Worker

Employment Status (Please Circle): Full Time Part-time Retired Disabled Not Employed

Job Title: _____ **Company:** _____ **Age:** _____ **U.S. Veteran**: Yes / No

Gender: _____ Male

_____ Female

_____ Transgender

If Transgender (Please Circle): Male/Female to Male Female/Male to Female Other
Decline to Answer

Sexual Orientation (Please circle): Straight (Not Lesbian or Gay) Lesbian or Gay Bisexual
Something Else Do Not Know
Decline to Answer

Race: African American: ___ Asian: ___ Hispanic: ___ White: ___ Native: ___ Other: _____

Ethnicity: Hispanic/Latino: Yes / No

Language (Please Circle): English Spanish Other (Please Specify) _____

Marital Status (Please Circle): Married Divorced Single Legally Separated

Emergency Contact: (Please list the nearest friend or relative NOT living with you)

Name of person: _____ Phone: _____

Relationship to patient: _____

Medical Home:

Are you receiving services from any other health/mental health agency? Yes:_____ No: _____

Please List Agency:_____ Contact Name: _____

Insurance:

Insurance Company: _____Policy Number: _____

Secondary Insurance: _____Policy Number: _____

Responsible Party: (if different from patient)

Name of person responsible for this account: _____

Relationship to patient: _____Address:_____ s

Income: (to determine eligibility for our DISCOUNT program, even if you have insurance)

Source (SSI, Wages, Food Stamps, etc.): _____ Number in Household: _____

Self- Reported: Yes _____ No _____Household Yearly Income Amount: _____

Advanced Directives: Do you have an Advanced Directive such as a Power of Attorney, Living Will, etc.?
Yes:_____ No:_____

Pharmacy- (please inform us if this changes)
Name of Pharmacy: _____ Location: _____

Patient Centered Medical Home Model- Selecting of Personal Clinician:
As a patient, the first step in managing your own care is to choose a team of care providers that you wish to provide your care. Each care team is led by your own personal clinician.

Please select your personal clinician from the list below.

Michelle Kiser, ARNP ____
Kimberly Turpin-Rose, ARNP ____

In the event that your personal clinician is out of the office or unavailable, one of our other clinicians will provide the same quality care as your personal clinician.

Client Signature: _____ Date: _____

Thank you for choosing Foothills Health and Wellness Center