PARTNERS IN HEALTH FAMILY MEDICINE

Questionnaire Form

PATIENT INFORMATION

Today's Date:	Marital status: ☐Single ☐Married ☐Divorced ☐Widowed

Patient Last Name:	First	M	Nickname:	Birth date:	Sex: ☐ M ☐ F

Address:	Social Security Number:
Apt No.:	Home Phone:
City/State:	Cell Phone:
Zip:	Email:

How did you hear about us? ☐Family/friend ☐Online ☐Insurance ☐Other______________________

Race: ☐ Asian ☐ Black/African American ☐ Native American Indian or Alaska Native ☐ Native Hawaiian ☐ Other/Pacific Islander ☐ White ☐ Refuse to Report

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Refuse to Report

Which Provider would you like to be primarily assigned to you?

☐ Mark Engelstad, MD ☐ Karen Burnett, MD ☐ Morgan Campbell, DO ☐ Aaron Shupp, MD ☐ Jeff Hilburn, PA

☐ Sarah Kleinschmidt, PA ☐ Heather Gray, PA ☐ Kathleen Slater, PA ☐ Alison Ruble, PA ☐ Unsure

Have you listed our practice as your Primary Care Provider (PCP)? ☐ NO ☐ YES ☐ UNSURE

How would you like to be contacted for appointment reminders? ☐ Patient Portal ☐ Telephone Call

Is it ok for us to send you appointment reminders, surveys, office notes, and newsletters to you through the mail? ☐ YES ☐ NO

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Address:	Phone Number:

OTHER INFORMATION

Do you have a caregiver/nurse that helps you at home or with daily living activities? ☐ YES ☐ NO

If yes Caregiver Name:	Caregiver Phone Number:

Have you completed a MOST form or have an Advanced Directive, Living Will, etc? ☐ YES. If yes please provide a copy at next visit ☐ NO

If you would like more information regarding above question, please ask your healthcare provider for more information.

Do you have a Legal Guardian or Medical Power of Attorney (POA)? ☐ YES ☐ NO

If YES, POA Name:	POA Phone Number:
POA Relationship to Patient:	

OFFICE USE ONLY

Initial stating you entered into system

______Nickname ______SS# ______Language ______Race ______Ethnicity ______PCP Name

______Does PCP name match ins card? ______Emergency contact info ______Advanced Directive

______Caregiver ______POA/Legal Guardian ______Questionnaire complete in system