# Family Health Care of Northwest Ohio, Inc.
# Registration Form: Please complete ALL sections

**PATIENT INFORMATION**

| Last Name | First Name | MI | Maiden Name | Date of Birth | Soc. Security Number |
|---|---|---|---|---|---|
| | | | | | |

**Sex at Birth:** ☐Male ☐Female

**Sexual Orientation:** ☐Straight ☐Lesbian/Gay ☐Bisexual ☐Don't Know ☐Something Else

**Gender Identity:** ☐Male ☐Female ☐Other ☐Transgender Male (Female to Male) Transgender Female ( Male to Female) ☐Choose not to report

| Address | City | State | ZIP |
|---|---|---|---|
| | | | |

**PREFERRED PROVIDER:** ☐ Megan Wehri, CNP ☐ Brittany Mawer, CNP ☐ Corie Mueller, PCNP ☐ Kendra Cross, CNP ☐ Dr. Gatz ☐ No Preference ☐ Dental Patient Only

**CONTACT INFORMATION**

| Home Phone ( ) | Day/ Work Phone ( ) | Cell Phone ( )<br>*For call/text*: FHC is not responsible for usage or data rates if applicable. |
|---|---|---|
| | | |

Special instructions for telephone calls:

**Preferred Contact Method:**
☐ Phone ☐ Mail ☐ E-Mail:

Please list your email address for access to your medical records through our secure online patient portal:
**Email Address:**

**EMERGENCY CONTACT:** Name: Phone Number: Relationship:

**TOTAL NUMBER OF HOUSEHOLD MEMBERS:**

**HOUSEHOLD INCOME:** ☐$0-$10,000 ☐$10,001-$20,000 ☐$20,001-$30,000 ☐$30,001-$40,000 ☐$40,001-$50,000 ☐$50,001-$60,000 ☐$60,001-$70,000 ☐ $70,001-$80,000 ☐ $80,001-$90,000 ☐ $90,001-$100,000 ☐$100,001+ ☐Decline Sliding Fee

**PLACE OF EMPLOYMENT:** **Preferred Pharmacy:**

**RESPONSIBLE PARTY** (Required for patients under 18 years of age)

| Last Name | First Name | MI | Soc. Sec. Number | Birth Date | Relationship |
|---|---|---|---|---|---|
| | | | | | |

**INSURANCE INFORMATION (Please present ALL insurance cards and a photo ID to the receptionist)**

| | | | | | | |
|---|---|---|---|---|---|---|
| Primary Insurance | Policy Holder | Date of Birth | Effective | Co-Pay | Policy # | Relationship |
| | Address | | | | Group # | |
| Secondary Insurance | Policy Holder | Date of Birth | Effective | Co-Pay | Policy # | Relationship |
| | Address | | | | Group# | |

**PATIENT INFORMATION FOR STATISTICAL REPORTING ONLY: PLEASE INDICATE ANSWERS FOR PATIENT**

Please **X** to indicate your race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race

Please **X** to indicate if you are Hispanic: ☐ Yes ☐ No

Please **X** to indicate if you are a Migrant worker: ☐ Yes ☐ No

Please **X** to indicate if you are a Seasonal worker: ☐ Yes ☐ No

Please **X** to indicate your preferred language: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other

Please **X** Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

Please **X** Student Status: ☐ Full-Time Student ☐ Part-Time Student

Please **X** if you are a: ☐ Veteran ☐ Smoker

Please **X** if you are: ☐ Homeless ☐ Doubling Up ☐ Transitional ☐ Shelter ☐ Street

Please list any spiritual/cultural beliefs that may affect your medical care:

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.
**I have received a copy of the Notice of Privacy Practices**
**The preceding information is true to the best of my knowledge.**

**Patient Name (Printed)** **Signature of Patient/Responsible Party** **Date**

Family Health Care of Northwest Ohio, Inc.

Health History Form

**Please complete this form in full related to your medical history. Do not leave anything blank or unanswered. This will allow FHC to give you the most appropriate care.**

| PATIENT INFORMATION | | |
|---|---|---|
| Patient Name: | Date of Birth: | Today's Date: |
| Do you have a Primary Care Provider? □ Yes □ No<br>If you do not use Family Health Care for Medical Care Who is your Primary Care Provider? List Below:<br>Providers Name:<br>City/State:<br>Phone Number: | Do you see any specialists? □ Yes □ No If yes, please list the providers name and what you see them for:<br>Dr. _____ Reason: _____<br>Dr. _____ Reason: _____<br>Dr. _____ Reason: _____<br>Dr. _____ Reason: _____ | |
| Do you have **Medication Allergies**? □ Yes □ No If yes, please list: | | |
| List all hospitalizations, recent ER Visits, reason and where: | | |
| List all Surgeries and approximate date: | | |
| Any orthopedic total joint replacements (hip, knee, elbow, shoulder)? □Yes □No | | Date: |

| Cardiovascular Disease | | Endocrine | | Hematologic (Blood) | |
|---|---|---|---|---|---|
| Heart related problems Please List: | □Yes □No | Diabetes Type I | □Yes □No | Clotting Disorder | □Yes □No |
| High Blood Pressure | □Yes □No | Diabetes Type II | □Yes □No | Anemia | □Yes □No |
| Valve Disease | □Yes □No | Hyperthyroidism | □Yes □No | Sickle Cell Anemia | □Yes □No |
| Do you have a Pacemaker | □Yes □No | Hypothyroidism | □Yes □No | AIDS/HIV | □Yes □No |
| Stent Placement | □Yes □No | Other: | | Other: | □Yes □No |
| Artificial Heart Valve | □Yes □No | **Digestive** | | **Neurologic** | |
| Heart Attack | □Yes □No | Cirrhosis of the liver | □Yes □No | Vertigo | □Yes □No |
| Peripheral Vascular Disease | □Yes □No | Gastric Ulcer | □Yes □No | Stroke | □Yes □No |
| Previous Infective Endocarditis | □Yes □No | Hepatitis | □Yes □No | Multiple Sclerosis | □Yes □No |
| Other: | | IBS | □Yes □No | Epilepsy/Seizures | □Yes □No |
| | | GERD | □Yes □No | Fainting | □Yes □No |
| | | Date of last Colonoscopy & location: | | Other: | |

| Behavioral Health | | Neoplasm (Cancer) | | Women Only | |
|---|---|---|---|---|---|
| Mental Health Problems Please List: | □Yes □No | Cancer present/past Type: | □Yes □No | Date of Last Pap Smear & location: | |
| ADHD | □Yes □No | Radiation | □Yes □No | Birth control: | □Yes □No |
| Bipolar | □Yes □No | | | Date of last Menstruation: | |
| Anxiety/Panic Disorder | □Yes □No | Chemotherapy | □Yes □No | Nursing/breastfeeding: | □Yes □No |
| Depression | □Yes □No | Remission | □Yes □No | Number of pregnancies: | |
| **Musculoskeletal** | | **Respiratory** | | Number of live births: | |
| Arthritis | □Yes □No | Asthma<br>Date of last attack: | □Yes □No | Pregnant:<br>Due Date: | □Yes □No |
| Back problems Please List: | □Yes □No | Emphysema | □Yes □No | Date of last Mammogram & location: | |
| Neck Pain | □Yes □No | Pulmonary Disease (COPD) | □Yes □No | Name and location OBGYN: | |
| Joint Pain | □Yes □No | Tuberculosis | □Yes □No | | |
| TMJ | □Yes □No | **Social History** | | Other-Please list any other disorder not listed: | |
| Osteoporosis | □Yes □No | Alcohol/Drug Misuse: | □Yes □No | | |
| Fibromyalgia | □Yes □No | Current Tobacco use: | □Yes □No | | |
| **Urology** | | □ Smoke □ Chew □ Vape | | | |
| Kidney/Bladder Problems | □Yes □No | Packs per day: | | | |
| Dialysis | □Yes □No | Recreational Drugs: | □Yes □No | | |

When was your last full physical exam? _____

Do you have a living will/Advanced Directive? □ Yes □ No

Do you have any impairments/communication needs? □ Yes □ No
If yes, please list:_____(Blindness, hearing loss etc.)

Has a physician or dentist recommended that you take an antibiotic prior to your dental treatment? □ Yes □ No

Have you ever taken any medications that affect bone density (osteoporosis)? □ Yes □ No
If yes please list: _____

Are you currently taking any blood thinners? □ Yes □ No
If yes please list: _____

Please list any chronic medical conditions that your biological parents and/or siblings (heart conditions, cancer, respiratory disorders Etc.) may have: _____

_____

_____

_____

_____

**Please list all medications you are currently taking:**
**Please include any over the counter medications and vitamins.**

| Medication Name | Dosage | Frequency |
|---|---|---|
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**Please list the pharmacy you are currently using:** _____

Patient/Guardian Signature_____ Date: _____