FIRST CHOICE PRIMARY CARE PATIENT INFORMATION

❑ **Check here if you need help filling out this application.**

Last Name	First Name	Middle Initial	Maiden or Previous Name

Street Address	City	State	County	Zip Code

Contact Number:
Home ______________________ Cell______________________ Alternate ___________________

Preferred number for us to call: ❑ Cell ❑ Home ❑ Work

Preferred time to call: ❑ Morning ❑Afternoon ❑ Evening

Also notify using: ❑ Email ❑ Text Message ❑ Patient Portal

Email Address: ____

Social Security Number	Marital Status	Sex ❑ F ❑ M	Date of Birth: Month _____ Date _____ Year _______

Emergency Contact Information

Name
____
Relationship to Patient_________________________
Address____
City, State, Zip ______________________________
Phone Number(s) ______________________________
Alternate Contact:______________________________

Residence Situation

❑ Permanent
❑ Public Housing
❑ Homeless
❑ Temporary with Family or Others/Doubled Up
❑ Salvation Army
❑ Rescue Mission
❑ Transitional Housing or Program
❑ Streets

Have you ever been in the military? ❑ Yes ❑ No
Are you a Veteran ❑ Yes ❑ No
Are you a Migrant ❑ Yes ❑ No
Seasonal Farm Worker? ❑ Yes ❑ No

Advance Directive
I have an Advance Directive ❑ Yes ❑ No
If no, would you like more information about Advance Directives? ❑ Yes ❑ No
❑ Living Will ❑ Durable Power of Attorney for Health Care

Race: ❑ Black/African American ❑ White ❑ Multiple Race ❑ Asian ❑ Native Hawaiian ❑ Pacific Islander ❑ American Indian/Alaska Native **Hispanic Ethnicity:** ❑ Yes ❑ No ❑ Prefer Not to Disclose Race/Ethnicity

Preferred Language: _________________________ **Do you need an interpreter?** ❑ Yes ❑ No

Currently Employed: ❑ Yes ❑ No **Name & Number of Employer**

Please select a Primary Care Provider ❑Timothy Graves, MD ❑Gwen Riggins, FNP ❑Rhonda Rountree, FNP ❑Jennifer Evans, MD ❑Tammy Stephens, FNP ❑No Preference/First Available

Is Patient Covered by Insurance? ❑ Yes ❑ No If yes Check all that Apply ***If yes, please give current card(s) to the receptionist.**

❑ Medicare
- ❑Part A Only
- ❑Parts A & B

❑ Medicaid
- ❑ Well Care
- ❑ Peach State
- ❑ Planning for Health Babies

❑ Blue Cross ❑ CIGNA ❑ Amerigroup ❑ Workers Comp ❑ Other _________________

Contracted Lab ❑ Lab Corp. ❑ Quest Diagnostic
***Please note it is the patient's responsibility to verify the lab your insurance company will cover. Without this information you will be responsible for any unpaid lab fees.**

Has the Patient Applied for Medicaid/Medicare Coverage?
❑ Yes ❑ No
Would you like more information on applying for coverage and other services? ❑ Yes ❑ No
Do you have access to regular Dental Care ❑ Yes ❑ No

Barriers to Healthcare/Nutrition

1. Does lack of transportation prevent you from getting to your appointments? ❑ Yes ❑ No
2. Does your family have access to healthy food?❑ Yes ❑ No
3. Is there enough food to cover the household?❑ Yes ❑ No
4. Do you have a ❑ Speech Impediment **and/or** ❑ Hearing Impaired?

Name of Other Person Responsible for Bill

Relation to Patient ❑ Parent ❑ Guardian ❑ Other ______________
You must provide proof of guardianship/Power of Attorney if not the legal parent.

Address	Contact Number

The foregoing information is true to the best of my knowledge and I request FCPC to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by FCPC. I acknowledge by signing below that I have received a copy of and read the FCPC HIPAA Privacy Policy Notice along with FCPC after hours contact.

Patient or Guardian Signature X_________________________________ **Date** ________________________