Head to Toe Family Healthcare
735 N. 5th Street
Silsbee, TX 77656
(409)385-6500 (409)385-6505 Fax

PATIENT INTAKE & HEALTH HISTORY FORM

DATE: ____/____/____

PATIENT INFORMATION

PATIENT NAME_____ **BIRTHDATE**____/____/____
LAST FIRST MIDDLE INITIAL

GENDER ☐MALE ☐FEMALE **MARITAL STATUS** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOW

STUDENT STATUS __ PART-TIME __ FULL TIME SOCIAL SECURITY # _____

MAILING ADDRESS: _____
STREET **CITY** **STATE** **ZIP**

EMAIL ADDRESS: _____

PHONE
☐ **HOME**_____ ☐ **CELL** _____ ☐ **WORK** _____ **CHECK PREFERRED CONTACT #**

EMPLOYER_____**ADDRESS**_____
STREET **CITY** **STATE** **ZIP**

Meaningful Use is the name of a new nationwide initiative to improve the health of our nation. As a part of this initiative, we are required to gather information for compliance with the Meaningful Use guidelines. Part of this information includes adding patient's race, ethnicity and preferred language to our electronic medical record. The government requires we gather this information to better identify possible disparities in access and quality of healthcare based on race and ethnicity on a national level. If you have questions, please visit the Office of the National Coordinator for Health Information Technology at www.healthit.hhs.gov and search "meaningful use".

ETHNICITY	☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐I CHOOSE NOT TO SPECIFY
RACE (CHECK ONE)	☐AMERICAN INDIAN/ALASKAN NATIVE ☐ASIAN ☐BLACK/AFRICAN AMERICAN ☐NATIVE HAWAIIAN/OTHER PACIFIC ISLAND ☐WHITE ☐I CHOOSE NOT TO SPECIFY
PREFERRED LANGUAGE	☐ENGLISH ☐OTHER _____ ☐I CHOOSE NOT TO SPECIFY

GUARANTOR

GUARANTOR _____
LAST FIRST MIDDLE INITIAL

RELATIONSHIP TO PATIENT: __ SPOUSE __ PARENT __ LEGAL GUARDIAN

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE:** _____

INSURANCE INFORMATION *(Please present a photo ID as well as your insurance card(s) with this completed form)*

PRIMARY INSURANCE _____ **POLICY HOLDER** _____
DOB___/___/_____
POLICY/SUBSCRIBER # _____**GROUP #** _____

SECONDARY INSURANCE _____ **POLICY HOLDER** _____

POLICY/SUBSCRIBER # _____**GROUP #** _____

EMERGENCY CONTACT

NAME: _____ **PHONE:** _____ **RELATIONSHIP:** _____

I authorize the release of any medical information necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits made to me or on my behalf to Head to Toe FHC for any services furnished me by said provider. **Responsible Party Signature:** _____ **Date:** _____/_____/____