New Patient Packet

Patient Information

Last Name: ________________________ First Name: _______________________ M/I: ____

Suffix: _________ Preferred Name: _____________________________________

Date of Birth: _____/_____/________ Sex at Birth: ☐ Male ☐ Female ☐ Decline to Specify
Month Date Year

Social Security Number*: ______-_____-_______
*Optional field used to verify medical insurance

Mailing Address: ____

City: ___________________________ State: ______________ Zip Code: ________________

Physical Address: ____

City: ___________________________ State: ______________ Zip Code: ________________

Phone Number: (______) _______________________ ☐ Home ☐Cell ☐Work

Phone Number: (______) _______________________ ☐ Home ☐Cell ☐Work

Have you Served in the US Military Forces or Uniformed Services? ☐ Yes ☐ No

Employer Name: ____

Occupation: ____

Employer Address: ____

City: ___________________________ State: ______________ Zip Code: ________________

Employer Phone Number: _______________________ Able to leave a message: ☐ Yes ☐ No

Responsible Party

Last Name: ________________________________ First Name: ______________________________

Date of Birth: ______/______/________

Relationship to Patient: ☐ Self ☐Father ☐Mother ☐ Legal Guardian

Phone Number: (______) ______________________ ☐ Home ☐Cell ☐Work

Phone Number: (______) ______________________ ☐ Home ☐Cell ☐Work

Street Address: ____

City: ___________________________ State: _______________ Zip Code: ______________

Emergency Contact Information

Last Name: ________________________________ First Name: ______________________________

Phone Number: (______) ______________________ ☐ Home ☐Cell ☐Work

Phone Number: (______) ______________________ ☐ Home ☐Cell ☐Work

Relationship to Patient: ☐Father ☐Mother ☐ Legal Guardian ☐Other: ____________________

Street Address: ____

City: __________________________ State: _______________ Zip Code: _______________

Pharmacy Information

Pharmacy Name: _______________________________

Address/Location: ____

Phone Number: (______) ______________________

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Health Insurance Information

Primary Insurance Information:

Subscriber Name (Name on Insurance Card): ____

Subscriber DOB: ______/______/_________ Subscriber SSN: ___________________________

Insurance Company: _____________________________

Subscriber ID#: __________________________________ Group#: ____________________________

Secondary Insurance Information:

Subscriber Name (Name on Insurance Card): ____

Subscriber DOB: ______/______/_________ Subscriber SSN: ___________________________

Insurance Company: _____________________________

Subscriber ID#: __________________________________ Group#: ____________________________

Tertiary Insurance Information:

Subscriber Name (Name on Insurance Card): ____

Subscriber DOB: ______/______/_________ Subscriber SSN: ___________________________

Insurance Company: _____________________________

Subscriber ID#: __________________________________ Group#: ____________________________

Dental Insurance Information:

Subscriber Name (Name on Insurance Card): ____

Subscriber DOB: ______/______/_________ Subscriber SSN: ___________________________

Insurance Company: _____________________________

Subscriber ID#: __________________________________ Group#: ____________________________

FQHC Required Demographics

Mosaic Health receives federal grant funding from the Health Resources and Services Administration (HRSA) to help us cover the costs of caring for you. To receive these funds, HRSA needs information about the people we care for as a whole. We ask for information about your age, race, ethnic background, household size and income. This also helps us to understand your unique healthcare needs so that we can provide you with the best care possible. We keep all your individual information confidential.

Patient's Primary Language:
Primary Spoken Language at home: ____
Interpreter Needed? ☐Yes ☐ No

Patient's Sexual Orientation:
☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Do not know ☐ Decline to Specify
☐ Other

Patient's Gender Identity:
☐ Male ☐ Female ☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male)
☐ Decline to Specify ☐ Other

Patient's Race (choose all that apply):
☐Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Asian (other)
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan
☐ Black/African American ☐ American Indian/Alaska Native ☐ White ☐ Decline to Specify

Patient's Ethnicity:
☐ Mexican ☐ Mexican American ☐ Chicano/Chicana ☐ Puerto Rican ☐ Cuban ☐ Hispanic/Latino Spanish Origin ☐ Not Hispanic/ Latino or Spanish Origin ☐ Other Hispanic/Latino or Spanish Origin
☐ Decline to Specify

Patient's Current Housing (check all that apply):
☐ Public Housing ☐ Homeless ☐ Transitional Housing ☐ Migrant Worker ☐ Seasonal Worker
☐ Group Home

Annual Household Income: (Please check box)

☐ Less than $11,000	☐ $30,001-35,000	☐ $55,001-60,000
☐ $11,001-15,000	☐ $35,001-40,000	☐ $60,001-65,000
☐ $15,001-20,000	☐ $40,001-45,000	☐ $65,001-70,000
☐ $20,001- 25,000	☐ $45,001-50,000	☐ $70,001-75,000
☐ $25,001-30,000	☐ $50,001-55,000	☐ Greater than $75,000

Household Size: _______
(Number of people in household this income supports.)

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Patient Authorization for Treatment

Authorization for Treatment I, the undersigned, hereby authorize medical/dental/behavioral health staff of Mosaic Health, Inc. to provide medical/dental/behavioral health care to myself or the above-mentioned patient if I am executing this document as a parent or guardian. I understand that my medical record will include information regarding the medical, dental, and behavioral health encounters by my Mosaic Health providers.

Financial Responsibility/Assignment of Benefits I authorize Mosaic Health, Inc. to apply for benefits on my behalf to my insurance carrier and request my insurance company pay directly to Mosaic Health, Inc. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify the Health Center of any changes. I understand that I am financially responsible for any services or procedures that may not be covered by my health insurance company including co-payments and deductibles and are due on the date of service. I further understand that if I am not covered by insurance or the Mosaic Health Sliding Fee Program, I am responsible for the payment of services in full.

Authorization for Release of Information I understand that my Mosaic Health encounters/visits are available to my Mosaic Health medical, dental and behavioral health providers to view. I authorize Mosaic Health, Inc. to release any health information necessary as to my, or the above-named patient's diagnosis and treatment to process any claims submitted to my insurance carrier on my, or the patient's behalf. A copy of this authorization may be used in place of the original. I authorize Mosaic Health, Inc. to forward a copy of my or the patient's health record to any provider to whom I am, or the patient is, referred for consultation. I understand that if I am, or the above-named patient is, in need of a referral for community services, including the County Department of Health and the County Department of Social Services, this authorization allows the exchange of medical information with agents of those community services. I understand that per New York mental hygiene law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct and Advance Care Directives I acknowledge that I have received a copy of Mosaic Health's Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct, and information on Advance Directives ("Your Questions Answered" Brochure, NYS Dept of Health "Deciding About Health Care" Guide and Health Care Proxy form).

______________________________	______________________________
Patient or Legal Guardian Signature	Printed Name
______________________________	______________________________
Relationship to Patient	Signature Date
______________________________	______________________________
Witness	Date