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## New Patient Packet

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M/I: \_\_\_\_\_

Suffix: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
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

*Are you a Veteran?*  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: (\_\_\_\_) \_\_\_\_\_



**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 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  Migrant Worker  Seasonal Worker

**Annual Household Income: (Please check box)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Less than \$11,000 | <input type="checkbox"/> \$30,001-35,000 | <input type="checkbox"/> \$55,001-60,000       |
| <input type="checkbox"/> \$11,001-15,000    | <input type="checkbox"/> \$35,001-40,000 | <input type="checkbox"/> \$60,001-65,000       |
| <input type="checkbox"/> \$15,001-20,000    | <input type="checkbox"/> \$40,001-45,000 | <input type="checkbox"/> \$65,001-70,000       |
| <input type="checkbox"/> \$20,001- 25,000   | <input type="checkbox"/> \$45,001-50,000 | <input type="checkbox"/> \$70,001-75,000       |
| <input type="checkbox"/> \$25,001-30,000    | <input type="checkbox"/> \$50,001-55,000 | <input type="checkbox"/> 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