Lewis County Primary Care Center Doing Business As...

PrimaryPlus

Quality ✚ Advanced ✚ Affordable ✚ Healthcare

PrimaryPlus Information Form

Medical Record#_____
(office use only)

LEGAL NAME: _____ _____ _____
Last First Middle Maiden

Preferred Name: _____ **Social Security**: _____ - _____ -_____

DOB: _____ **Preferred Provider/Clinician**:_____
(This is the provider that you primarily want to see and to manage your overall care)

Your Address:_____
Street City State/Zip Code

Preferred Pharmacy: _____

Do you speak and understand English? Yes No

Gender: (circle one) Male Female Transgender Other Choose not to disclose
Assigned sex at birth: (circle one) Male Female Choose not to disclose
Pronouns: (circle one) he/him she/her they/them

Sexual orientation: (circle one) Lesbian or gay Straight (not lesbian or gay) Bisexual
Something else Don't know Choose not to disclose

Marital Status: (circle one) Single Married Divorced Widowed Separated

Race: (circle one) White Black Asian American/Indian **Ethnicity:** Hispanic Non-Hispanic
(If biracial, circle the race you most identify as)

Contact Information: (Please list numbers and options we may use to contact you)
Home Phone : _____ Cell/Mobile Phone: _____
Consent to call? Yes No Consent to text? Yes No
Consent to leave message? Yes No Consent to call? Yes No
Work Phone:_____Consent to call? Yes No Consent to leave message? Yes No

Email Address: _____

Employer:_____ **Occupation**:_____

Veteran Status: Veteran Non-Veteran

Agricultural Work Status: Non-Agricultural Employed Year-Around Seasonal Migrant Retired Farmer

Homeless Status: Do you consider yourself homeless? Yes No

Public Housing: Yes No patient declined

PLEASE COMPLETE BACK OF FORM

Insurance: _____Private Insurance _____Medicare _____Medicaid _____Self Pay/No Insurance

Primary Insurance:

Insured/ Spouse Information

Name:_____ Relation:_____ Phone:_____

Birth Date:_____ Social Security:_____- _____- _____

Emergency Contact Information:

Name: _____ Relation:_____ Phone:_____

Primary Caregiver (if applicable):_____ DOB_____
(Person who provides day-to-day care for the patient) Name

Legal Guardian (for minors):_____ DOB _____
Name

Do you have legal documents? Yes No
If yes, please submit appropriate documents to front desk staff

(Non-applicable for children under the age of 18)

Do you have a **Power of Attorney or Health Care Proxy/Surrogate**? Yes No
(An "agent" designated by the patient, the patient's family, or by the courts to make health care decisions for him or her in the event that the patient is unable to do so)

If YES, please submit appropriate documents to front desk staff

Do you have a **Living Will or Advance Directives?** Yes No
(Documents which give the patient a voice in decisions about their medical care when he/she is unconscious or too ill to communicate)

If YES: Please submit to front desk staff to be copied

If NO: And you would like additional information, please ask front desk staff for an informational packet

Patient Signature:_____ Date:_____