PRISM HEALTH

NEW PATIENT PAPERWORK – PATIENT INFORMATION

PLEASE READ: Prism Health recognizes all genders and identities; however, many insurance companies and legal entities unfortunately do not. Please be aware that the legal name and sex you have listed with your insurance must be used on documents pertaining to insurance and billing. When addressing you, we will always use the name and pronouns that you request to assure that we are using the most respectful language.

Please let us know if there is anything we can do to make your time with us more comfortable. Thank you.

PATIENT REGISTRATION	**TODAY'S DATE:**
Name on File with Your Insurance Last: First: Middle:	Date of Birth (MM/DD/YYYY):
Name You Go By:	Social Security Number:

Sex Assigned at Birth:	☐ Male ☐ Female ☐ Intersex
Legal Sex:	☐ Male ☐ Female ☐ X
Pronouns You Use:	☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Hir/Hirs ☐ Xe/Xem/Xyrs ☐ Ve/Vir/Vis ☐ Ey/Em/Ers ☐ Name. ☐ Another: _____ ☐ Decline / Prefer Not to Answer
Gender Identity:	☐ Woman ☐ Man ☐ Non-Binary ☐ Gender Non-Conforming ☐ Two Spirit ☐ Cisgender ☐ Transgender ☐ Questioning ☐ Another: _____ ☐ Decline / Prefer Not to Answer
Sexual Orientation	☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Asexual ☐ Pansexual ☐ Straight ☐ Questioning ☐ Another: _____ ☐ Decline / Prefer Not to Answer
Relationship Structure	☐ Single ☐ Monogamous ☐ Polyamorous ☐ Open/Non-Monogamous ☐ Aromantic ☐ Kink/BDSM ☐ Questioning ☐ Another: _____ ☐ Decline / Prefer Not to Answer
Ethnicity:	☐ Hispanic ☐ Non-Hispanic ☐ Don't Know ☐ Choose Not to Say
Race:	☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Middle Eastern/North African ☐ White ☐ Don't Know ☐ Choose Not to Say ☐ Another: _____

Physical Address: City: State: ZIP:	Employer: Occupation: ☐ Full-Time ☐ Part Time

Main Phone:	Work Phone:	Other Phone:
Email:		

PRISM HEALTH

NEW PATIENT PAPERWORK – PATIENT INFORMATION CONT.

INSURANCE INFORMATION Please note: Co-pays are due at time of service	
Insurance Name:	ID Number:
Who is the insurance subscriber?	☐ Yourself ☐ Someone Else
When did your insurance start?	Month: Year:
Are you interested in utilizing our **SLIDING SCALE**? If yes, please complete the following. If no, please skip.	
Do you make less than $25,520 per year?	☐ Yes ☐ No, skip the rest ☐ Unsure
Current Annual Income:	$
Number of People in Your Household:	
Source of Income:	
Estimated Annual Income: ☐ < $25,520 ☐ $25,520 - $40,000 ☐ $40,001 - $75,000 ☐ $75,001 - $100,000 ☐ > $100,000	
PREVIOUS PROVIDER INFORMATION	
Are you transferring your care from another healthcare provider?	☐ Yes ☐ No
If yes, please list the name and phone number for your previous provider. We will also ask you to fill out a Release of Information so we can obtain your medical records.	
Name of Provider:	Phone Number:
Are you a US Veteran?	☐ Yes ☐ No
EMERGENCY INFORMATION	
Emergency Contact Name:	
Relationship:	Phone:

Patient Name: _____ DOB: _____

PRISM HEALTH

NEW PATIENT PAPERWORK – MEDICAL HISTORY

MEDICAL HISTORY
Please check ALL that apply:

☐ Alcohol Use	☐ Chronic Pain	☐ Heart Disease	☐ Seizures
☐ Asthma	☐ Depression	☐ Hepatitis	☐ Sleep Apnea/ Snoring
☐ Anemia	☐ Dental Issues	☐ High Blood Pressure	☐ Strokes/TIA
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ STD/STI
☐ Blood Clots	☐ Dialysis	☐ HIV/AIDS	☐ TB
☐ Cancer	☐ Drug Addiction	☐ Insomnia	☐ Tobacco Use
☐ COPD	☐ Headaches	☐ Mental Health Issues	☐ Ulcers

REVIEW OF SYSTEMS
Please check ALL that apply and have occurred within the last three months, and lasting several days:

BLOOD	☐ Anemia	☐ Clots	☐ Fatigue	☐ Bleeding Issues
CARDIOVASCULAR	☐ Chest Pain	☐ Feet/Leg Swelling	☐ Fainting	☐ Palpitations
GASTROINTESTINAL	☐ Nausea/Vomiting	☐ Constipation	☐ Diarrhea	☐ Heartburn
GLANDS/HORMONES	☐ Cold Intolerance	☐ Heat Intolerance	☐ Menopause	☐ Menstrual Issues
MENTAL HEALTH	☐ Anxiety	☐ Depression	☐ Hallucinations	☐ Suicidal Ideations
MUSCULOSKELETAL	☐ Pain	☐ Stiffness	☐ Swelling	☐ Weakness
NEUROLOGICAL	☐ Weakness	☐ Headaches	☐ Neck/Back Pain	☐ Limb Numbness
OB/GYNECOLOGICAL	☐ Burning	☐ Cramps	☐ Pregnancy	☐ Itching
RENAL	☐ Kidney Stones	☐ Urgency/Pain	☐ Blood in Urine	☐ Incontinence
RESPIRATORY	☐ Cough	☐ Shortness of Breath	☐ Wheezing	☐ Wet Cough
SKIN	☐ Bruising	☐ Burns	☐ Itching/Rash	☐ Wounds

MEDICATIONS
List all of your current medications and dosage. Include over-the-counter, vitamins, supplements, CPAP machines, allergy medications, and anything else you take:

Medication Name	Dose	Frequency

ALLERGIES
List all medication and other allegories (food, latex, etc.) you have, as well as the reaction (hives, rash, swelling, etc.):

Allergy	Reaction

Patient Name: _____ DOB: _____

PRISM HEALTH

NEW PATIENT PAPERWORK – SEXUAL HEALTH

SEXUAL HEALTH	
Question	Response
Are you currently sexually active?	☐ Yes ☐ No
If no, have you been sexually active in the past?	☐ Yes ☐ No
Are your sex partners (check all that apply)?	☐ A person with a penis ☐ A person with a vagina
What body parts do you use when you have sex?	☐ Penis ☐ Vagina ☐ Anus ☐ Vagina
Has there been any change to your sexual desire?	☐ Yes ☐ No
If yes, please describe the change:	
Have you had vaginal or anal sex with someone living with HIV?	☐ Yes ☐ No ☐ Not Sure
Have you had vaginal or anal sex with someone that uses injection drugs?	☐ Yes ☐ No ☐ Not Sure
What method(s) of birth control do you use?	☐ Condom ☐ IUD ☐ Spermicide ☐ NuvaRing ☐ Depo ☐ Dental Dam ☐ Withdrawal ☐ Patch ☐ None ☐ Another: _____
Are you trying to become pregnant?	☐ Yes ☐ No ☐ N/A
On a scale of 1-5, with 1 being never and 5 being always, how often do you use condoms?	☐ 1 - Never ☐ 2 - Rarely ☐ 3 – Half of the time ☐ 4 - Almost Always ☐ 5 - Always
Have you ever exchanged sex for something you need?	☐ Yes ☐ No
Have you ever had an STD/STI?	☐ Yes ☐ No
If yes, please check all that apply:	☐ Gonorrhea ☐ Herpes ☐ Chlamydia ☐ Syphilis. ☐ HPV ☐ HIV ☐ Another: _____
Have you ever been tested for HIV?	☐ Yes ☐ No
Would you like to be tested for HIV?	☐ Yes ☐ No
Would you like any other STI testing today?	☐ Yes ☐ No
Do you have pain during intercourse?	☐ Yes ☐ No ☐ Sometimes
Do you have any questions or concerns about your sexual health?	☐ Yes ☐ No
If yes, please explain:	

Patient Name: _____ DOB: _____

PRISM HEALTH

NEW PATIENT PAPERWORK – PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last two weeks, how often have you experienced the following issues? **Please check each number that corresponds with your answer.**	Not At All	Several Days	Almost Every Day	Every Day
Little interest or pleasure in doing things:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, hopeless, or depressed:	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling/staying asleep or sleeping too much:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy:	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling badly about yourself:	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating at work or school:	☐ 0	☐ 1	☐ 2	☐ 3
Moving/speaking slowly or being fidgety/restless	☐ 0	☐ 1	☐ 2	☐ 3
Thoughts of suicide or hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
Totals of each column:				
If you checked off any of these problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with people?	☐ 0	☐ 1	☐ 2	☐ 3

Patient Name: _____ DOB: _____

PRISM HEALTH

NEW PATIENT PAPERWORK – ALCOHOL USE QUESTIONNAIRE

Alcohol Use Questionnaire
Drinking alcohol can affect your health and some medications you take. Please help us provide you with the best medical care by answering the questions below. Let your provider know if you have any questions.

Questions	Never	Monthly or Less	2 – 4 Times per Month	2 – 3 Times per Week	4+ Times per Week
How often do you have a drink containing alcohol?	☐	☐	☐	☐	☐
How often do you have 4 or more drinks on one occasion?	☐	☐	☐	☐	☐
How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐
How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐
How often during the last year have you been unable to remember what happened the night before because of your drinking?	☐	☐	☐	☐	☐
How many drinks containing alcohol do you have on a typical day when you are drinking?	☐ 0 - 2	☐ 3 - 4	☐ 5 - 6	☐ 7 - 9	☐ 10+
Have you or someone else been injured because of your drinking?	☐ No	☐ Yes, but not in the last year		☐ Yes, in the last year	
Has a relative, friend, doctor, or health care worker been concerned about your drinking or suggested you cut down?	☐ No	☐ Yes, but not in the last year		☐ Yes, in the last year	

Patient Name: _____ DOB: _____

PRISM HEALTH

NEW PATIENT PAPERWORK – DRUG USE QUESTIONNAIRE

SEXUAL HEALTH	
Question	Response
Please mark all substances that you have used in the last 12 months:	☐ Cocaine ☐ Inhalants (aerosol, glue, etc.) ☐ Marijuana ☐ Narcotics (heroine, oxycodone, etc.) ☐ Tranquilizers (Valium, Xanax, etc.) ☐ Hallucinogens (LSD, mushrooms, etc.) ☐ Methamphetamines (speed, crystal, etc.) ☐ Other: _____
If so, how often have you used these drugs?	☐ Monthly or less ☐ Weekly ☐ Daily or almost daily
Have you used drugs other than those required for medical reasons?	☐ Yes ☐ No
Do you use more than one drug at a time?	☐ Yes ☐ No
Are you unable to stop using drugs when you want to?	☐ Yes ☐ No
Have you ever had blackouts or flashbacks as a result of drug use?	☐ Yes ☐ No
Do you ever feel bad or guilty about your drug use?	☐ Yes ☐ No
Do your family, partner(s), and/or friends ever complain about your involvement with drugs?	☐ Yes ☐ No
Have you neglected your family because of your drug use?	☐ Yes ☐ No
Have you engaged in illegal activities in order to obtain drugs?	☐ Yes ☐ No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐ Yes ☐ No
Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions)?	☐ Yes ☐ No

Patient Name: _____ DOB: _____