Family Health Services	**Title:** Patient Intake	ID #: FD1000 Effective: 07/20/2026 Page: 1
	PHONE: 419-502-2800 • FAX: 419-502-2821	

Family Health Services (FHS) is a Federally Qualified Health Center (FQHC), and we are required to ask the following questions and are required to report on the information annually. You do have the right to refuse to report. All information will remain confidential and will be used for reporting purposes only. Patient intake forms and consents will need to be updated annually.

PATIENT INFORMATION:

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE:	SOCIAL SECURITY #:

PREFERRED NAME:	PATIENT'S PRIMARY PHYSICIAN:

PATIENT BILLING ADDRESS (RESPONSIBLE PARTY):	CITY:	STATE:	ZIP:
PATIENT RESIDENCE (IF DIFFERENT):	**CITY:**	**STATE:**	**ZIP:**

WHICH CONTACT # DO YOU PREFER:
☐ Home: (_____)_____
☐ Cell: (_____)_____
☐ Work: ( )_____
EMAIL: _____

CAN WE SEND NOTIFICATIONS? (CHECK ALL THAT APPLY)
☐ Opt-Out ☐ Phone
☐ Text ☐ Voicemail
☐ E-Message

CONSENT TO SHARE DATA WITH EXTERNAL HEALTHCARE ENTITIES?
☐ Opt-In
☐ Opt-Out
☐ Emergency

BIRTH GENDER:
☐ Male ☐ Female

MARITAL STATUS:
☐ Single ☐ Married
☐ Widowed ☐ Divorced
☐ Separated ☐ Life Partner

PRIMARY LANGUAGE:
☐ English ☐ Spanish
☐ Chinese ☐ Japanese
☐ French ☐ Russian
☐ Arabic
☐ OTHER: _____

RACE:
☐ American Indian/Alaska Native
☐ Asian ☐ Asian Indian ☐ White/Caucasian
☐ Black/African American ☐ Samoan
☐ Native Hawaiian ☐ Hawaiian/Pacific Islander
☐ Chinese ☐ Japanese ☐ Korean
☐ Filipino ☐ Vietnamese ☐ More than one race
☐ Other Pacific Islander ☐ OTHER: _____

ETHNICITY:
☐ Non-Hispanic or Latino/Spanish Origin
☐ Hispanic or Latino/Spanish Origin
☐ Mexican/Mexican American/ Chicano
☐ Cuban
☐ Puerto Rican
☐ Decline to Answer

INSURANCE INFORMATION (Please present ALL insurance cards and picture ID to the front desk)

FOR SCHOOL BASED CLINICS: Copies of the identification cards and insurance cards can be made at the school or a picture (front and back of each card) can be emailed to clinicinfo@familyhs.org.

Primary Insurance	Policy #	Group #	Effective	Policy Holder	Relationship
Secondary Insurance	Policy #	Group #	Effective	Policy Holder	Relationship
Dental Insurance	Policy #	Group #	Effective	Policy Holder	Relationship

ADVANCED DIRECTIVE:

Do you have a living will? ☐ YES ☐ NO If yes, is it on file with your Primary Care Provider? ☐ YES ☐ NO

REQUIRED REPORTING

PERMANENT HOUSING:
☐ House/ Apt/ Mobile Home

Family Size: _____

Family Income:

$_____

☐ Refuse to Report

TEMPORARY/TRANSITIONAL HOUSING:
☐ Shelter
☐ Homeless/Street/Car
☐ Transitional
☐ Temporarily Living with Friends/Family
☐ Permanently Living with Friends/Family
☐ Other: _____

VETERAN:
☐ YES ☐ NO

MIGRANT AGRICULTURE WORKER:
☐ YES ☐ NO

SEASONAL AGRICULTURE WORKER:
☐ YES ☐ NO

PREFERRED PHARMACY:

_____

CITY:

_____

RESPONSIBLE PARTY:

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE:	SOCIAL SECURITY #:	RELATIONSHIP:

EMPLOYER NAME:	EMPLOYER ADDRESS:	EMPLOYER PHONE:
	_____ _____	

IF PATIENT IS UNDER18 YEARS OLD:				
Is there custody involvement? ☐ YES ☐ NO **If yes, please see the front desk to complete the Authorization for the Treatment of Minors**				
Parent/Guardian #1		**Parent/Guardian #2**		
FIRST NAME:	**LAST NAME:**	**FIRST NAME:**	**LAST NAME:**	
PHONE NUMBER:		**PHONE NUMBER:**		
EMERGENCY CONTACT:				
LAST NAME:	**FIRST NAME:**	**BIRTH DATE:**	**PHONE NUMBER:**	**RELATIONSHIP:**

I understand that by signing this form, I agree to pay all balances pertaining to the services rendered. If I do not pay or should my account become delinquent, I realize that my information may be sent to a collection agency. I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, to communicate with me for any reason by any telephone number, email and mailing address provided. I understand that Family Health Services offers a sliding fee scale to all patients. The sliding fee scales levels are posted within the clinics and copies are available upon request. I may at any time request an application for the sliding fee scale from Family Health Services.

By signing below, I also acknowledge that the named patient has received a copy of the Notice of Privacy Practices and Patient Rights (a copy of the notice is included in your intake paperwork). This notice provides information about how we may use and disclose protected health information about you/the patient.

Signature of Patient/Responsible Party:	Date:	☐ Patient ☐ Parent ☐ Guardian
Patient Name/Responsible Party (PRINT):		