Health Care for the Entire Family

ROANE COUNTY FAMILY HEALTH CARE

146 Williams Drive, Spencer, WV 25276
Phone: 304.927.1495
Fax: 304.927.8198

www.rcfhc.org

Patient's Name _____
(Last, First, Middle)

Social Security No. : _____ Date of Birth: _____

Race: ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ White
☐ American Indian/Alaska Native ☐ More than one Race ☐ Unreported/Refused to Report Race

Gender: ☐ Male ☐ Female ☐ Transfender Male/Female-to-Male ☐ Transgender Female/Male-to-Female
☐ Other ☐ Choose not to Disclose

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to Disclose

Marital Status: Single Married Divorced Widowed

Legally Responsible Party Information

Name: _____ Home Phone #: _____
(Last, First, Middle

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Social Security No.

Employer: _____ Work Phone #: _____

Whom may we contact in case of an emergency?: _____ Phone #: _____
Relationship to Patient?

Number in household: _____ Approximate Yearly Income: _____

Education

Highest level of education completed: _____

Insurance Information

☐ Medicaid (Dept. Of Health & Human Resources) #: _____

☐ Medicare #: _____

☐ Other Public Insruance Name: _____

Group #: _____ Plan ID#: _____

Employer Plan: (Yes) (No) Prepaid: (Yes) (No)

☐ Not Insured Have you applied for Sliding Fee at Family Health Care? (Yes) (No)

Appointment Notifications

Do you wish to receive messages/reminders by text and/or email? (Yes) (No)

If Yes, please provide the following:

Cell Phone #: _____ Name of Cell Phone Company: _____

Email Address: _____

Health History

Allergies/Reasctions (medications, foods, plants, latex, etc):

All Medications you are currently taking

Medication	Strength	How Often

Surgeries or Medical Illnesses

Surgery or Illness	Year

Have you or a blood relative had any of the following? (If relative, how are you related?)

- ☐ Stomach Disorder
- ☐ Eating Disorder
- ☐ Menstrual Disorder
- ☐ Heart Condition
- ☐ Sexual Disorder
- ☐ Special Education/Learning Disability
- ☐ High Blood Pressure
- ☐ Seizure Disorder
- ☐ Kidney Problems
- ☐ Skin Condition
- ☐ Bleeding Problems
- ☐ Lung Disease
- ☐ Mood Swings
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Other

Name and ages of your children: _____

Health/Personal Habits

- ☐ Smoking - # of Cigarettes per day _____
- ☐ Drink Alcohol (Occ) (Binge) (Every day)
- ☐ ALWAYS wear seat belts
- ☐ Snuff or Chewing Tobacco
- ☐ Caffeine (pop, tea, coffee)
- ☐ Use Birth Control

Are you aware of the practices of safe sex? (Yes) (No)

FEMALES ONLY: Do you think you could be pregnant? (Yes) (No)

Would you like to talk about birth control? (Yes) (No)

How many times have you been pregnant? _____

Signature of parent or personal representative

Date: _____

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