INTAKE FORM

PLEASE COMPLETE THIS FORM AND MAKE UPDATES AS NEEDED.

Legal Last Name:		**Today's Date:**
Legal First Name:		**Preferred Name:**
Date of Birth:	**Age:**	**SSN:**
Address:		**City:**
State:	**Zip:**	**County:**
Sex at birth: ☐ Male ☐ Female ☐ Intersex	**Gender:** ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Something Else	
Do you need a translator? ☐ Yes ☐ No	**If yes, what language?**	
Patient Portal ☐ Yes, opt-in for Patient Portal	☐ No, opt-out	
Would you like to opt in for access to **telehealth**? Famcare will need to send you email and text messages ☐ Yes, opt-in for Telehealth ☐ No, opt-out		

Famcare is dedicated to protecting your privacy. These questions help us ensure your information is secure. You can update your preferences at any time.

For information about your appointment or follow-up, can we contact you by:

Mail? ☐ Yes ☐ No	**Email?** ☐ Yes ☐ No	**Text?** ☐ Yes ☐ No	**Phone?** ☐ Yes ☐ No
If we call, who should we say is calling? ☐ Famcare ☐ Doctor's Office ☐ A Friend			
Cell Phone Number:		**Home Phone:**	
Email address:		**Preferred Method:** ☐ Cell ☐ Home ☐ Email	

Pharmacy:	
Race: (check all that apply) ☐ Black ☐ White ☐ Pacific Islander/Native HI ☐ American Indian/Alaskan Native ☐ Asian ☐ More than one race ☐ Other	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered	
Household income: ☐ Yearly ☐ Monthly ☐ Bi-weekly ☐ Weekly **Income Amount:**	
Family Size (How many people supported by this income?)	
If you have children, how many live with you?:	
Medicaid: ☐ Yes ☐ No	
Primary Insurance Name:	
Secondary Insurance Name:	

Did you talk about coming to Famcare with any family or trusted adult? ☐ Yes ☐ No	**If yes, with who?**
Emergency Contact Name:	**Relationship:**
Emergency Contact Phone:	

Patient Signature Date