Hoxie Medical Clinic
826 18th St, Suite A
Hoxie, KS 67740

Today's Date________________

*Please fill this form out to its entirety.

If you need assistance, please ask!

Patient's Legal Name: ____Birthdate:______________
First Middle Last

Preferred Name: _________________________________ Gender at Birth: ____Male ____Female

Physical Address: _____________________________ Mailing Address: _________________________

City: _____________________________________State:_________________ Zip:________________

Phone: ___________________________________ Cell:______________________________________

Email:____
How would you like us to contact you for appointment reminders? Phone Call Text* Email
*Standard messaging and data charges through your phone company may apply

Emergency Contact: _______________________________________ Relationship: _________________
First Last

Home Phone:______________________________ Cell Phone:________________________________

Marital Status: __Married __Single __Divorced __Widowed __Separated __Life Partner __Minor

Employment Status: __Full Time __ Part Time __Unemployed __Retired __Homemaker __Student
Job Title/Occupation: ____

Primary Language: __English __Spanish __German __Italian __French __Japanese
__Portuguese __Sign Language __Chinese __ Other ____________________________________

Housing Status: __Single Family Housing __Multiple Family Housing __Homeless (Shelter)
__Homeless (Street) __ Transitional/Temporary __Public Housing (income based housing)
__ Senior Housing __ Other ____

Agricultural Status: (We participate in the Kansas Farmworker Health Program)
___Migrant Worker or Dependent of--An individual whose principle employment is in agriculture **and** who establishes a temporary home for the purposes of employment.

___Seasonal Worker or Dependent of--An individual whose principle employment is in agriculture on a seasonal basis **but** who does not establish a temporary home for the purposes of employment.

___Neither Migrant nor Seasonal Worker

Race (choose all that apply): __ Caucasian (White) __Asian __ African American __Native Hawaiian
__ Other Pacific Islander __ American Indian or Alaskan Native

Ethnicity: __ Hispanic or Latino __ Non- Hispanic or Latino

Sexual Orientation: __ Straight or Heterosexual __Gay, Lesbian or Homosexual __ Bisexual
__Something Else __ Don't know

Patient's Initials: _____________

Gender Identity: __ Male __ Female __ Transgender Male __Transgender Female __ Other

Have you ever served in the military? ___ Yes ___ No (We do participate in the Veteran's Choice Program.)

INSURANCE

_____No Health Insurance (Patient Navigator is available to discuss possible options.)

Primary Insurance: ___Private ___Medicare ___Medicaid ___Other_________________________

Secondary Insurance: ___Private ___Medicare ___Medicaid ___Other________________________

Household Size and Income – Find the correct number of people in your household and circle the range of annual income from all sources that supports your household*:

*Household definition: Anyone living in the same household related by blood or marriage. To include adopted child(ren) and foster child(ren).

1 Person	2 People	3 People	4 People
$0- $12,060	$0- $16,240	$0- $20,420	$0- $24,600
$12,061- 18,090	$16,241-24,360	$20,421- 30,630	$24,601- 36,900
$18,091- 24,120	$24,361- 32,480	$30,631- 40,840	$36,901- 49,200
$24,121 and over	$32,481 and over	$40,841 and over	$49,201 and over

5 People	6 People	7 People	8 People or More
$0- $28,780	$0- $32,960	$0- $37,140	$0-41,320
$28,781-43,170	$32,961- 49,440	$37,141- 55,710	$41,321- 61,980
$43,171- 57,560	$49,441- 65,920	$55,711- 74,280	$61,981- 82,640
$57,561 and over	$65,921 and over	$74,281 and over	$82,641 and over

***Please note- All income information is kept strictly confidential and is needed for reporting purposes only. You have the right to refuse to provide this information.**

_____Refused

We do have a Sliding Fee Discount Program for patients with no insurance or not enough insurance. This is based on household size in ratio to household income. Proof of income is **required**.
I would like additional information regarding the Sliding Fee Discount Program. Yes No

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Medical History

Patient's Name: ____ Birthdate: ___________________
First Last

Name of Primary Doctor: __________________________________Doctor Phone: __________________

Past Hospitalizations or Serious Illnesses:	Date:
Past Surgeries:	**Date:**

Please use the back of this page for overflow information.

Allergies – to medicine/food/other agents:	Reaction or Side Effect:

Current Medications:	Dose:	Times Per Day:

Social History: (Please circle where appropriate)

Caffeine intake per day: None 1-5 cups 5+ cups

Exercise: None Occasional Regular (weekly) Frequent (Daily)

Alcohol: None Occasional Regular (weekly) Frequent (Daily)

Tobacco: None Former Current some days Current everyday Type:____________________

Drug Use – Recreational __ Y __ N Drug used: ______________________ Needles used: __Y __N

Date of Immunizations: Tetanus (TD) ___________ Pneumonia: __________Flu Vaccine: ___________

Physical:
Date of last Colonoscopy: ____________ Last Eye Exam: _____________Last Dental Exam:___________

Women Only: Date of Last Pap Smear: _____________________ Mammogram: __________________
Number of Pregnancies: _______ Number of Live Births _________

Patient's Initials: _____________ Adopted- Family history unknown ___

Medical History:	**Self**	**Mother**	**Father**	**Child(ren)**	**Siblings**	**Grandparents or Immediate Relative**
Alcoholism						
ADHD/ Learning Disability						
Asthma						
Arthritis						
Bleeding Disorder						
COPD						
Congenital/ Genetic Disorder						
Diabetes						
Epilepsy/ Seizures						
Emphysema						
Glaucoma						
Hearing Problems/ Loss						
Heart Disease						
High Blood Pressure						
High Cholesterol						
HIV Positive						
Kidney Disease						
Liver Disease/ Hepatitis						
Mental Health Disorders						
Migraines						
Multiple Sclerosis						
Neurological Disorder						
Osteoporosis						
Obesity						
Peptic Ulcer Disease						
Stroke						
Scoliosis						
Stomach Problems						
Tuberculosis						
Thyroid Disorder						
Cancer ______________						
Cancer ______________						
Other _______________						