mosaic health
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Patient Information

Last Name	First Name	Middle	Suffix	Preferred Name	DOB

Mailing Address	Apt	City	State	Zip	County
Physical Address	**Apt**	**City**	**State**	**Zip**	**County**

Phone Number	Appointment Reminders	Email Address
Cell ____________________ Home_________________	☐ Phone ☐ Text ☐ Morning ☐Afternoon	Interested in Patient Portal ☐ Yes ☐ No
Social Security Number	**Employer Name**	

Veteran ☐ Yes ☐ No	Primary Spoken Language	Interpreter Needed? ☐ Yes ☐ No

As a Federally Qualified Health Center (FQHC), we can offer services to all our patients, including the underserved, because of our federal designation. As an FQHC, we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistical purposes only. We appreciate you taking time to complete all questions in this section.

Marital Status	Ethnicity	Race	
☐ Single	☐ Mexican/Mexican American/Chicano	☐ Asian Indian	☐Native Hawaiian
☐ Married	☐ Puerto Rican	☐ Chinese	☐ Other Pacific Islander
☐ Divorced	☐ Not Hispanic, Latino, or Spanish origin	☐ Filipino	☐ Guamanian or Chamorro
☐ Separated	☐ Other Hispanic, Latino, or Spanish Origin	☐ Japanese	☐ Samoan
☐ Other	☐ Cuban	☐ Korean	☐ Black/African American
	☐ Decline to specify	☐ Vietnamese	☐ American Indian/Alaska Native
		☐ Other Asian	☐ White/Caucasian
		☐ More than one race	☐ Decline to specify

Sexual Orientation	Gender Identity	Sex at Birth
☐ Straight or Heterosexual	☐ Male	☐ Male
☐ Lesbian or Gay	☐ Female	☐ Female
☐ Bisexual	☐ Transgender Female (Male to Female)	☐ Choose not to disclose
☐ Something Else ___________________	☐ Transgender Male (Female to Male)	
☐ Don't know	☐Genderqueer, neither exclusively male or female	
☐ Choose not to disclose	☐Something else, please describe_______________	
	☐ Choose not to disclose	

Household Information

Patient lives (check if apply)
☐ Public Housing ☐ Homeless ☐ Transitional Housing ☐ Migrant Worker ☐ Seasonal Worker ☐ Group Home

Annual Household Income
☐ <$11,000 ☐ $11,000-$15,000 ☐ $ 15,001-$20,000 ☐$20,001-$25,000 ☐25,001 - $30,000 ☐ $31,001-$35,000 ☐ $35,001-$40,000 ☐$40,001-$45,000 ☐ $45,001-$50,000 ☐$50,001-$55,000 ☐$55,001-$60,000 ☐$60,001-65,000 ☐$65,001-$70,000 ☐$70,001-$75,000 ☐Greater than $75,000

Household Size _______ (Number of people in household this income supports)

Emergency Contact Information

First Name	Last Name	Phone Number	
Relationship to patient ☐ Spouse ☐ Partner ☐ Parent ☐ Child ☐ Other _______________			
Mailing Address	**City**	**State**	**Zip**

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Primary Insurance Information Patient Insurance Information		
Subscriber Name (Name on insurance card)	Subscriber SSN	Subscriber DOB
Plan Carrier (Insurance company)	Subscriber ID#	Group #
Secondary Insurance Information		
Subscriber Name (Name on insurance card)	Subscriber SSN	Subscriber DOB
Plan Carrier (Insurance company)	Subscriber ID#	Group #
Dental Insurance Information		
Subscriber Name (Name on insurance card)	Subscriber SSN	Subscriber DOB
Plan Carrier (Insurance company)	Subscriber ID#	Group #

Responsible Party				
Last Name	First Name	Relationship to Patient	Phone Number	Address

Pharmacy Information	
Name of patient's primary pharmacy	Address/Location

Patient Authorization for Treatment

Authorization for Treatment I, the undersigned, hereby authorize medical/dental/behavioral health staff of Mosaic Health, Inc. to provide medical/dental/behavioral health care to myself or the above-mentioned patient if I am executing this document as a parent or guardian. I understand that my medical record will include information regarding the medical, dental and behavioral health encounters by my Mosaic Health providers.

Financial Responsibility/Assignment of Benefits I authorize Mosaic Health, Inc. to apply for benefits on my behalf to my insurance carrier and request my insurance company pay directly to Mosaic Health, Inc. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify the Health Center of any changes. I understand that I am financially responsible for any services or procedures that may not be covered by my health insurance company including co-payments and deductibles and are due on the date of service. I further understand that if I am not covered by insurance or the Mosaic Health Sliding Fee Program, I am responsible for the payment of services in full

Authorization for Release of Information I understand that my Mosaic Health encounters/visits are available to my Mosaic Health medical, dental and behavioral health providers to view. I authorize Mosaic Health, Inc. to release any health information necessary as to my, or the above-named patient's, diagnosis and treatment to process any claims submitted to my insurance carrier on my, or the patient's behalf. A copy of this authorization may be used in place of the original. I authorize Mosaic Health, Inc. to forward a copy of my or the patient's health record to any provider to whom I am, or the patient is, referred for consultation. I understand that if I am, or the above-named patient is, in need of a referral for community services, including the County Department of Health and the County Department of Social Services, this authorization allows the exchange of medical information with agents of those community services. I understand that per New York mental hygiene law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct and Advance Care Directives I acknowledge that I have received a copy of Mosaic Health's Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct, and information on Advance Directives ("Your Questions Answered" Brochure, NYS Dept of Health "Deciding About Health Care" Guide and Health Care Proxy form).

________________________________ ________________________________

Patient/Parent or Guardian Signature   Printed Name/Relationship to Patient

________________________________ ________________________________

Witness   Date