

New Health Care Consumer Questionnaire

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) - Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.*

Patient Name \_\_\_\_\_ Gender  M  F  
Last First Middle

Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

If the person completing this form is not the patient, please write your name, your relationship to the patient, and why you are completing the form for this patient.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Reason \_\_\_\_\_

Reason For Visit \_\_\_\_\_

Patient's Personal Contact Information (Address and Phone)

\_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact (Address and Phone)

\_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Information (Insurance Company, Policy Number, Contact Number)

\_\_\_\_\_ Contact # \_\_\_\_\_

Policy# \_\_\_\_\_ Fax (if known) \_\_\_\_\_

Additional, or Secondary Insurance Company

\_\_\_\_\_ Contact # \_\_\_\_\_

Policy# \_\_\_\_\_ Fax (if known) \_\_\_\_\_

Have you completed a Living Will OR designated a Durable Power of Attorney for Health Care?  Yes  No  
If yes, please provide a copy for your health care provider.

Do you have any religious or cultural beliefs that may impact my health care  Yes  No  
If yes, please describe \_\_\_\_\_

Methods of learning new material that I like best are:

Verbal Instruction  Written Instruction  Handouts  Visual (Pictures, Videos, etc)

You Do  You Do Not understand English well. The language you prefer \_\_\_\_\_

Level of education completed

<6<sup>th</sup> grade  6<sup>th</sup> - 8<sup>th</sup> grade  9<sup>th</sup> grade  12<sup>th</sup> grade  1-4 years college  >4 years college

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The information on this page was reviewed with the patient

HCC Initials \_\_\_\_\_ HCP Initials \_\_\_\_\_