Demographic Form

Family First Health Care
Capac - Armada

Date:_____

PATIENT INFORMATION

Legal Name (*Last, First, Middle*) **Date of Birth::**

Maiden Name : **Preferred Name:**

Mailing Address: **City & State:** **Phone #**

City & State: **Z ip Code:** **Cell Phone #** **Cell Phone Carrier:**

Sex at Birth:

[ ] Male

[ ] Female

Sexual Orientation:

[ ] Heterosexual/straight
[ ] Homosexual/lesbian/gay
[ ] Other please describe:
_____

Gender Identification:

[ ] Male

[ ] Female

Maritial Status:

[ ] Single *[ ] Married*
[ ] Divorced *[ ] Seperated*
[ ] Widow/widower

Email Address:

[} YES, I would like to be able to have access to my health record through FFHC online Patient Portal

Race:

[ ] American Indian or Alaskian Native
[ ] Asian
[ ] African American
[ ] Pacific Islander
[ ] Caucasian
[ ] Hispanic
[ ] Other

Ethnicity:

[ ] Hispanic/Latin
[ ] Not hispanic/latin
[ ] Refuse to stay
[ ] None

Language:

[ ] English
[ ] Spanish
[ ]_____

PHARMACY:

Primary Pharmacy _____City/state:_____ Ph:_____

Secondary Pharmacy:_____City/state:_____ Ph:_____

Mail Order Pharmacy:_____City/state:_____ Ph:_____

INSURANCE:

Are you the primary insured? [ ] Y [ ] N

If you are not the primary, please complete the section below:

Relationship to the primary insured: [ ] Self [ ] Spouce [ ] Child [ ] Other

Is this person a patient here: [ ] Y [ ] N

Name of Primary Insured_____

SSS:_____ DOB:_____Phone #:_____

Address (if diferrent from above): _____

Name of Secondary Insurance:_____

EMERGENCY CONTACT

Name:_____Relation to you:_____Phone #:_____
Name:_____Relation to you:_____Phone#:_____
Name_____Relation to you:_____Phone#:_____

May staff members contact your Emergency Contacts to discuss your protected health information? [ ] Y [ ] N

New Patient Medical History Form

Family First Health Care
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Name:_____

DOB:_____

Date:_____

Are you aware of any medication allergies? [ ] Y [ ] N

Allergies	Reaction

Are you taking any medications? [ ] Y [ ] N

Name of Medication	Strength	How may times per day

Have you had any surgeries? [ ] Y [ ] N

Type of Surgery	Date of Surgery	Surgical Facility/Surgeon

You may utilize the back of this page if more room is needed to list you medications, allergies, or surgeries

New Patient Medical History Form

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Name:_____

DOB:_____

Date:_____

Have you been diagnosed with health conditions? [ ] Y [ ] N

Please check all that apply

Diagnosis	Current	Past	Comments
Alcoholism			
Drug Abuse			
Asthma			
Cancer (type?)_____			
Depression/bipolar/anxiety (circle all that apply)			
Diabetes type 1 or 2			
COPD or Emphysema			
Heart isease			
Hight blood pressure			
High cholesterol			
Thyroid disorder (type?)_____			
Kideny disease			
Migraines			
Stroke			
Retinopathy			
Other:			

Social History

Occupation:_____	**Employer:**_____
Circle all that apply: Full-time Part-time Retired Disabled LOA	**Years of education or Degree:**_____
Do you use tobacco/nicotine? [ ] Y [ ] N	**History of tobacco/nicotine use?** [ ] Y [ ] N
Circle all that apply: Vape Cigarettes Pipe Cigar Chew Other	**Packs per day?**_____ **How long?**_____ **Quit Date:** _____
Alcohol use: [ ] Y [ ] N **Circle all that apply:** Beer Wine Liquor	**Amount of alcohol consumed in a week?**
Marijuana or Recreational drugs? [ ] Y [ ] N	**Current or history of using needles for drug use?** [ ] Y [ ] N
Caffeine use? [ ] Y [ ] N **Circle all that apply:** Coffee tea soda	**How much caffeine per day?**_____

New Patient Medical History Form

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Name:_____

DOB:_____

Date:_____

Health History

Social History

Are you currently sexually active: [ ] Y [ ] N	**Sexual partners is/have been:** [ ] Male [ ] Female	**Method of Birth Control:** [ ] Pills/ring/patch/injection/IUD [ ] Condom [ ] Vasectomy
Martial Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Other	**Children?** [ ] Y [ ] N	**If yes, how many?**_____
Exercise? [ ] Y [ ] N	**Minutes per day:**_____ **Days per week:** _____	**Type of Exercice:**
Average hours of sleep per night: _____	**My diet is:** [ ] Good [ ] Average [ ] Poor	**Do you use a bike helment:** [ ] Y [ ] N
Guns in the home: [ ] Y [ ] N **Are they locked up:** [ ] Y [ ] N	**Working smoker detectors:** [ ] Y [ ] N	**Do you use seat belts regularly:** [ ] Y [ ] N
Is violence at home a concern: [ ] Y [ ] N	**Do you have an Advanced Directive or Living Will:** [ ] Y [ ] N	

Specialist Involved With Your Care

Speciality	Name/location
Cardiology	
Nephrology (kidney specialist)	
Gastroenterologist (stomach/digestive)	
OB/gyn	
Neurologist	
Pain Management	
Pulmonologist (lung)	
Endocrinologist	
Dermatologist	
Allergist	
Urologist	
Previous Family Physician	
Other	

New Patient Medical History Form

Family First Health Care
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Name:_____

DOB:_____

Date:_____

FAMILY HISTORY [ ]Known family History [ ]No known family History:	Diabetes 1 or 2	High Blood pressure	High Cholesterol	Hypothyroidism	Heart disease	Kidney Disease	Stroke	Asthma	Depression	Anxiety	Bipolar	Alcohol Abuse	Drug Abuse	Cancer (list type): _____	Other:
Mother															
Father															
Son															
Daughter															
Sister															
Brother															
Maternal Grandmother															
Maternal Grand father															
Paternal Grandmother															
Paternal Grandfather															
Other: _____															

Any Additional Pertinent Health Information

Please List Below:

Date of your last mammogram:
Date of your last pap smear:
Date of your last colonoscopy:
Date of your last cholesterol screening:
Date of your last PSA scareening:
Date of your last wellness exam:
Additional health information:

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Capac - Armada

24 Hour Cancellation & "No Show" Fee Policy:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Family First Health Care serves the right to charge a fee of $25.00 for all missed appointments/no shows that are not cancelled within 24 hours of the appointment time or without good cause.

"No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in discharge from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name: _____

Signed Name:_____

Date:_____

Family First Health Care
Capac - Armada

Dear Patient,

Given the current climate in our country surrounding opioid pain medications, we have been compelled to evaluate our current prescribing habits and the use of opioid pain medications among our patients. Every day, more than 90 Americans have died due to opioid overdose. The issue has become a public health crisis and has been named a top priority by the US Department of Health & Human Services. It is our obligation as prescribers to do what we can to reduce the opioid epidemic that is claiming many lives.

Although there are certainly situations in which the use of opioid pain medication is appropriate, long-term use of these medications is rarely indicated. If there is a situation in which opioids are prescribed to you for longer than 3 months, please be aware of the following:

- You may be referred to a chronic pain management specialist.
- We perform random urine drug screening.
- These medications will not be prescribed over the phone.
- Regular evaluations of the continued need for the medication will occur.
- Certain medications, such as those for anxiety and insomnia, may not be prescribed as they pose a dangerous risk of overdose when combined with opioids.
- The medication may be stopped at any time if deemed no longer appropriate by the prescriber.

Our goal as an office is to provide each patient with safe and effective care. We thank you in advance for your cooperation in assisting us to help combat the opioid crisis in our country. We ask that you sign this letter to acknowledge that the above-stated expectations have been reviewed and understood.

Sincerely,

Loren J. DeCarlo, D.O.

Karey Hartford, F.N.P.

Pamela Kuzera, F.N.P.

Sarah Hunger, F.N.P.

Printed name:_____

Signature:_____

Date:_____

Family First Health Care

Capac - Armada

Loren J. DeCarlo, D.O.

Patient-Centered Medical Home

Right for our office right for you

As a part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the enclosed and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.

We strive to provide you with top comprehensive care.
We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice.

If you have any question, please ask.

As a part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the enclosed and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.
We strive to provide you with top comprehensive care.
We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice.
If you have any question, please ask.

I understand and agree with this Patient Centered Medical Home standard:

Printed name:_____

Signature:_____

Date: _____

Form Reviewed by provider/physician

Signature: _____ Date: _____

Family First Health Care
117 S. Main St.
Capac, MI, 48014
Ph: 810.395.4840
Fax: 810.395.7551

Family First Health Care
22905 W. Main St.
Armada, MI, 48005
PH: 586.473.8082
Fax: 586.473.8129

What Are Your Options?

A Medical Home is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowwledges the role of each in a total health care program.

Helping You Make The Right Choices

Over the next several months you may notice that We ask you to help us plan your care to let us know if think you can follow the plan. Written copies of care plans may be given in more complex illnesses.

The care team members are doing more and/or different parts of the care.

We remind you when test are due so that you can receive the best quality care.

We may ask you to have blood test done prior to your visit so that the doctor has your results at your visit.

We Are exploring methods to care for you better, including ways to help you care for yourself.

WE Trust You, Our Patient, To:

Tell us what you know about your health and illnesses.

Tell us about your needs and concerns.

Take part in planning your care.

Follow the care plan that is agreed upon or let us know why you cannot so that we can try to help, or change the plan.

Tell us what medications you are taking and ask for a refill at your office visit when you need one.

Let us know when you see other doctors and what medications they prescribed to you or what medication changes were made.

Ask other doctors to send us a report about your care when you see them.

Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialist.

Learn about wellness and how to prevent disease.

Learn about your insurance so you know what it covers.

Respect us as individuals and partners in your care.

Keep your appointments as scheduled or call and let us know when you cannot.

Pay your share of the visit fee when you are seen.

Give us feedback so we can improve our services (we may survey you in the future to understand this better).

WE Will Continue To:

Provide you with a care team who will know you and your family.

Respect you as an individual, we will not make judgements based on race, religion, sex, age, disability, ect.

Respect your privacy - your medical information will not be shared with anyone unless you give us permission or it is required by law.

Provide care given by a team of people led by your physician.

Give the care you need, when you need it.

Give care that meets your needs and fits with your goals and values.

Have a doctor on call 24 hrs a day 7 days a week.

Take care of short illness, long term disease, and give advice to help you stay healthy.

Tell you about your health and illnesses in a way you ca understand.

To improve your care we are using technology - like our Electronic Health Record synstem and we will strive to continuously improve.

Standard Practice Hours:

Capac	Armada
Mon: 8am - 4pm	Mon: 8am - 4pm
Tue: 8am - 7pm	Tues: 8am - 7pm
Wed: 8am - 7pm	Wed 8am - 4pm
Thurs: 8am -4pm	Thurs: 8am-7pm
Fri: 8am - 4pm	Fri 8am - 4pm

Sat availability varies call for days and time

We strive to accommodate patients who need urgent care. Please call us if you are in need of medical care or if you need guidance regarding your medical care. Emergency care is crucial, allowing us to provide the ER with information about your health situation can make it safer and more effective. By sharing important details about your medical history, medications, and allergies, we can help ensure that you receive the best possible care in an emergency situation.

Insurance Particication

At our healthcare facility, we participate with a variety of health care plans. We understand that some plans may be better suited for preventative care, while others may offer more choices. Our goal is to ensure that you access the care you need, when you need it.

Dr. Loren J. DeCarlo, D.O.

Karey Hartford, FNP

Family First Health Care
Capac - Armada

Pamela Kuzera, FNP

Sarah Hunger, FNP

Family First Health Care
Capac - Armada

AVAILABLE COMMUNITY SERVICES

Need Help??? 2-1-1 is now available in St. Clair County. Dial 211 from any phone, and you will be connected with a referral hotline that can connect you with a local non-profit agency. The non-profit agency can help with human, health, and social needs (utilities, housing, health insurance, food, diapers, and more). Available 24 hours a day and 7 days a week.

Comprehensive Quality of Care

Please be aware, in the course of providing you with medical care, your health care information may be shared among other providers involved in your care, as appropriate.

Remember when you visit your specialist, or when you visit an urgent care or ER/hospital:

Let us know when you see other doctors, go to an urgent care, go to an ER, or have been admitted to the hospital. Please carry an updated medication list. When receiving medication treatment from another facility/provider, have them send all reports to us (your PCP).

Family First Health Care
Capac - Armada

We strive to accommodate patients who need urgent care treatment. Please call us to guide your care. As always, if your situation is life-threatening, call 911.

Urgent Care Center:
Henry Ford Macomb
80650 Van Dyke Rd., Bruce, MI
810.798.6410

McLaren Port Huron ER
1221 Pine Grove Ave., Port Huron, MI
810.987.5000

Mclaren Lapeer Regional
1254 N. Main St. Lapeer, MI
810.664.4531