EL BUEN SAMARITANO
STRENGTHENING FAMILIES

PATIENT PROFILE

Contact Information

Today's Date: ____ / _____ / ______

Please print all information and use legal name.

Last Name	First Name	Middle Name	Date of Birth ____ / _____ / _______

Address	Apt. #	City	State	County	Zip Code

Home Phone #	Cell Phone #	Other Phone #	Email Address

Emergency Contact:

Name: _________________________

Relationship: _________________

Phone: ________________________

If patient is under 18 years old:

_____ Parent _____Legal Guardian

Name: ________________________ Date of Birth: ___ / ___ / _____

Relationship: _________________

Phone: ________________________

Do you have an Advance Medical Directive?

- ◻ No
- ◻ Yes *(Please provide a written copy for documentation in your medical record.)*

Demographic Information

Social Security Number (if applicable): __________________

ID Type: ____

Number: ____

Gender:
- ◻ Female
- ◻ Male

Marital Status:
- ◻ Single
- ◻ Married
- ◻ Divorced
- ◻ Widowed

Hispanic/Latino(a):
- ◻ Yes
- ◻ No

Race:
- ◻ Hispanic/Latino
- ◻ White
- ◻ Black /African American
- ◻ American Indian/Alaska Native
- ◻ Asian
- ◻ Native Hawaiian or Other Pacific Islander
- ◻ Two or More Races (Not Hispanic/Latino)
- ◻ Decline to respond

Employment Status:
- ◻ Unemployed
- ◻ Employed

____
Occupation

Preferred Language:

____

Highest Education Level:
- ◻ Primary School
- ◻ Junior High/High School
- ◻ Technical/Vocational School
- ◻ Some College
- ◻ Bachelor's Degree
- ◻ Master's Degree

Income Verification

Monthly household income: _______________ Number of people in my immediate family: ________

Acknowledgment and Consent for Treatment

_______ *(initials)* I certify that the information provided above is true, to the best of my knowledge.

_______ *(initials)* I understand that all information concerning medical, social services, counseling and/or any other services that I receive at El Buen Samaritano is confidential. Thus, all information will be protected and shared as designated in the *Notice of Privacy Practices* and as limited by law. I have been notified that El Buen may share information internally when deemed appropriate to facilitate my ongoing care. Generally, information may not be disclosed to any other person or agency outside of El Buen without my written authorization.

_______ *(initials)* I authorize El Buen Samaritano's medical providers and their assistants or their designees to carry out medical and diagnostic procedures that may be deemed necessary and/or advisable for my health care. I voluntarily consent to these services. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the result of such treatment or examination.

_______ *(initials)* I consent to receive electronic communications from El Buen Samaritano such as text messages to my cell phone, emails for appointment reminders or messages from my provider through the secure online Patient Portal. I understand that this authorization will apply to all future appointments, unless I request a change in writing.

____ or ____
Patient Signature / Signature of Parent or Guardian

____ or ____
Patient's Printed Name / Printed Name of Parent of Guardian

____
Date Signed

Patient Centered Medical Home (PCMH) Philosophy

In your patient packet, you will find more detailed information about the PCMH partnership, including what you can expect from our care team, your rights and responsibilities as a client of El Buen and an explanation of how we may use and disclosure your individual health information, including our participation in a health information exchange (HIE) known as *ICare*. We encourage you to discuss PCMH with our staff. We will be happy to answer your questions.

PCMH Orientation Packet Received

Patient Signature: ____ Date: ___________________

PCMH Orientation Packet Reviewed and Signatures Witnessed

Employee Signature: ____ Date: ___________________