MOBILE UNIT HEALTH QUESTIONNAIRE

FORM MUST BE COMPLETED & SIGNED EVERY YEAR

Patient Information

Last Name: _____ First Name: _____

Today's Date: _____ Social Security Number: _____-_____-_____ Date of Birth: _____ / _____ / _____

Home Address: _____

Primary Phone Number: _____ Gender: Male Female Trans

Can we text you with routine reminders? ☐ Yes ☐ No Number To Receive Text Messages: _____

Race *you may choose more than one race: Asian White Black/African American

Native Hawaiian American Indian/Alaska Native Other Pacific Islander

Ethnicity: Hispanic/Latino Not Hispanic/Latino **Language Spoken: _____**

Insurance Information

Insurance: ☐ Medicaid ☐ Commerical ☐ Medicare ☐ Uninsured Medical Insurance Company: _____

Cardholder Name: _____ Policy Number: _____ Group: _____

Secondary Insurance: ☐ Yes ☐ No If Yes, Policy Number: _____

Primary Doctor Name: _____ Primary Doctor Phone Number: _____

Date of Last Physical: _____ ☐ I've included a copy of my most recent physical

Name of Pharmacy: _____ Pharmacy Address: _____

Name of Dentist: _____ Date of Last Dental Appointment: _____

Emergency Contact Information

*We require the name, address and phone number of 2 contacts who can be called if you are unavailable.

Name of Contact : _____ Phone and/or Cell: _____

Alternate Number: _____ Relationship to Patient: _____

Name of Contact : _____ Phone and/or Cell: _____

Alternate Number: _____ Relationship to Patient: _____

BOTH SIDES OF FORMS MUST BE COMPLETE- INCOMPLETE FORMS WILL NOT BE ACCEPTED

Medical Information

*Please list any medication that you take on a regular basis. (pills, sprays, inhalers, etc.)

Medication	Dosage	When do they take it	Why do they take it

Are you taking a multivitamin: ☐ Yes ☐ No Are you taking a fluoride supplement? ☐ Yes ☐ No

Do you have ANY allergies: ☐ Yes ☐ No
If yes, please list and explain reaction: _____

Have you ever been diagnosed with ANY of the following conditions: ☐ Asthma ☐ Diabetes ☐ ADHD

Do you have ANY serious illness or medical conditions? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Have you have ANY serious injuries or accidents? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Have you had ANY surgery? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Have you EVER been hospitalized overnight? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Does anyone in your family smoke? ☐ Yes ☐ No If yes, where: ☐ Inside ☐ Outside

Are there any health, social, or academic concerns that you would like to make us aware of? ☐ Yes ☐ No

If yes, please explain: _____

_____

Patient Signature: _____

Patient Name: _____ Date: _____

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MOBILE UNIT CONSENT FOR HEALTH SERVICES

The following services will be provided on the Mobile Unit (MU):

1) Comprehensive physical exams
2) Age-appropriate immunizations
4) Assessment and treatment for acute and chronic conditions, minor injuries and emergency care
5) Health and nutrition education and counseling
6) Prescriptions
7) Referrals to outside specialists
8) Oral Health screening and fluoride varnish

I hereby give consent to receive health care services including, but not limited to any age-appropriate care provided by the professional staff of the Whitney Young Health (WYH)'s MU.

- I further give consent to the staff of the MU to examine my full medical and school records, including any information that may assist them in my care. In addition, if necessary, WYH may contact my family physician or any other healthcare providers to share information regarding my treatment and WYH may exchange medical information as needed for coordination of care purposes.
- I hereby give consent to the staff of the MU to obtain copies of my most recent physical exam and immunization records from my Primary Care Provider.
- I further consent to the staff of the MU to obtain my medication history from external sources to be better informed about potential medication issues and use that information to improve safety and quality of care.
- I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier for services rendered by WYH's MU.
- I understand if my insurance coverage does not permit WYH to be reimbursed for the care provided, I am responsible for payment to WYH for services rendered.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms I have received a copy of Whitney M. Young, Jr. Health Services Privacy Practices, as well as the Patient Bill of Rights and Patient Responsibilities.

Signature: _____ Name: _____

SIGNED FORMS ARE VALID AS LONG AS YOU ATTEND A SITE THAT HOSTS
THE WHITNEY YOUNG MOBILE UNIT

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