Welcome to
Brown Health Medical Group Primary Care!

New Patient Packet

Primary Care
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www.brownhealth.org/primarycare

Primary Care
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Welcome to Brown Health Medical Group Primary Care

Thank you for choosing us for your primary care needs! Our team-based model—consisting of physicians, advanced practice providers, and on-site and centralized support staff—is in place to help ensure you receive the timely, high-quality care you deserve.

To help us provide you with the best experience possible, please review the information below and complete the included new patient forms prior to your visit. Completing these forms in advance helps your appointment run smoothly and confirms we have all the necessary details to address your healthcare needs.

Forms to Complete
Please fill out the following documents prior to your appointment:

- Shared Expectations for Care Agreement (*page 3*)
- New Patient Registration Forms *(pages 4-10)*
- Permission to Discuss/Disclose Protected Health Information (PHI) *(page 11)*
- Primary Care Provider (PCP) Attestation Form *(page 12)*
- Authorization to Obtain Protected Health Information (PHI) (*separate page, visit bit.ly/auth-phi*)

What to Bring to Your Appointment
Please bring the following items to your visit – and, if able, print the checklist from *bit.ly/bhmgpc-checklist*:

- Co-payment *(if required by your plan)*
- Your insurance card(s)
- Valid photo identification
- List of any medications you are currently taking

Programs and Services

- Care365 provides same-day adult sick visit appointments on evenings, weekends, or holidays. To schedule a Care365 appointment, call 401-606-2365 or visit *bit.ly/365visits* for more details.
- We also offer same-day sick visits in your practice during standard office hours, along with laboratory services, clinical programs, health education classes, etc. For details, visit *bit.ly/bhmgpc-services*.

Policies and FAQs – Including Rescheduling, No-Shows, and Code of Conduct
If you need to reschedule an appointment, please contact us at least 24 hours in advance to allow us to offer the time to another patient. Multiple "no-shows" for appointments may result in a discharge from our practices. Additionally, please note that words or actions that are disrespectful, racist, discriminatory, hostile, or harassing toward staff or other patients will not be tolerated. View our policies/FAQs at *bit.ly/bhmgpc-policiesfaq* and read our Shared Expectations for Care agreement on the following page.

We look forward to caring for you! Thank you for trusting us with your health care.

Sincerely,

Your care team at Brown Health Medical Group Primary Care

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Patient name (Print): _____

Preferred name: _____

Preferred pronoun: _____

Patient date of birth: _____ Date: _____

Shared Expectations for Care Agreement

Code of Conduct
Brown Health Medical Group Primary Care is committed to the physical and mental well-being of our patients, staff, and visitors while maintaining an inclusive and caring environment. As our patient, you can and should expect Brown Health Primary Care team members to treat you with kindness and respect in every interaction we have. We also expect the same in return from our patients and visitors. Words or actions that are disrespectful, racist, discriminatory, hostile, or harassing will not be tolerated and may result in discharge from a Brown Health Primary Care practice or legal action. This includes the following: • Offensive comments about others' race, accent, religion, gender, sexual orientation, or other personal traits • Sexual or vulgar words or actions • Refusal to see a clinician or other staff member based on the above personal traits • Physical or verbal threats and assaults At Brown Health Primary Care, we foster and value a culture of shared decision-making between our clinicians and patients. We reserve the right to discontinue patient care at Brown Health Primary Care if the relationship between the clinician, care team members, and the patient is not respectful.

Missed Appointments
Brown Health Medical Group Primary Care strives to provide timely and consistent access to care for all our patients. As a courtesy to our clinicians providing care and other patients seeking to receive care, we ask that you communicate any appointments you are unable to keep at least 24 hours in advance so that we may use this time to serve other patients in need. Please note that repeated missed appointments without timely communication with your practice may result in the termination of your care at Brown Health Medical Group Primary Care.

Patient Transfers
If you voluntarily transfer your care out of Brown Health Medical Group Primary Care to another local practice, please note that we may not be able to readily accommodate the continuation of your care at Brown Health Medical Group Primary Care.

By signing this form, I acknowledge that I have reviewed and understand the expectations for care at Brown Health Medical Group Primary Care described above.	
Name:	Date of birth:
Signature:	Date:

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Patient name (Print): _____

Preferred name: _____

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Patient date of birth: _____ Date: _____

Introduction

Patient Information & Preferences *(Please print or type)*		
Last name:	First name:	Middle initial:
Preferred name:		Date of birth:

Insurance	
Primary insurance:	Subscriber number:
Secondary insurance:	Subscriber number:

Your Major Health Concerns or Questions
What matters most to you about your health?

Medications

Below, list all the medications that you take regularly or have taken regularly in the past month (including aspirin products, vitamins, birth control pills, etc.):

Drug	**Drug strength**	**How often you take the drug each day**	**Length of time you have taken the drug**

Do you need medication refills today? ☐ Yes ☐ No *If yes, please list below:*

1.	2.	3.
4.	5.	6.

Are you having problems affording your medications? ☐ Yes ☐ No

Allergies
List any drug allergies (if any, briefly describe the reaction):

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Personal Background

Sexual Orientation and Gender Identity		
Please answer the following questions regarding your sexual orientation and gender identity:		
Birth sex:	☐ Male ☐ Female ☐ Unknown	
What is your gender identity:	☐ Male ☐ Female	
	☐ Female-to-male (FTM)/transgender male/trans man	
	☐ Male-to-female (MTF)/transgender female/trans woman	
	☐ Genderqueer, neither exclusively male nor female	
	☐ Other:	
	☐ Choose not to disclose	
What is your sexual orientation:	☐ Lesbian, gay, or homosexual	☐ Straight or heterosexual
	☐ Bisexual	☐ Do not know
	☐ Other:	☐ Choose not to disclose
What is your current relationship status?	☐ Single ☐ Partner ☐ Married	

Education			
What is the highest level of education you reached in school?	☐ Elementary	☐ High School	☐ College
	☐ Other:		
How do you prefer to learn new information?	☐ Doing/demonstration ☐ Reading/written materials ☐ Watching/video or presentations		

Race, Ethnicity, and Language		
What is your race?	☐ American Indian or Alaska Native	☐ Asian
	☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander
	☐ White	☐ Other:
	☐ Declined to Answer	☐ Unknown
What is your ethnicity?	☐ Hispanic or Latino	☐ Not Hispanic or Latino
	☐ Declined to Answer	☐ Unknown
What is your primary language?	☐ English	☐ Spanish
	☐ French	☐ Portuguese
	☐ Other:	

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Preferred name: _____

Preferred pronoun: _____

Patient date of birth: _____ Date: _____

Social History and Habits

Drugs, Alcohol, and Exercise		
Do you drink alcoholic beverages (wine, beer, liquor, etc.)? ☐ Yes ☐ No		
If yes, how many alcoholic beverages do you have on average in a week?		per week
Do you smoke? ☐ Yes ☐ No		
If no, have you ever smoked? ☐ Yes ☐ No		
Please tell us how many years you have/had been a cigarette smoker:		year(s)
Have you ever tried to quit smoking? ☐ Yes ☐ No		
How many days per week do you exercise for at least 20 minutes?		days per week

Sexual Activity			
Are you sexually active? ☐ Yes ☐ No			
What method of contraception do you use? *(Select all that apply)*	☐ Birth control pill	☐ Condom	☐ Diaphragm
	☐ Other:		
Have you ever been diagnosed with a sexually transmitted illness? ☐ Yes ☐ No			

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Past Medical History

Medical Conditions	
Place a checkmark next to the illness or illnesses that you currently have or have had in the past:	
☐ Anemia or other blood conditions	☐ Hypothyroidism (Underactive Thyroid)
☐ Anxiety	☐ Irritable Bowel Syndrome (IBS)
☐ Asthma	☐ Migraines
☐ Celiac Disease	☐ Multiple Sclerosis (MS)
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Osteoarthritis
☐ Coronary Artery Disease	☐ Osteoporosis
☐ Depression	☐ Parkinson's Disease
☐ Diabetes	☐ Post-Traumatic Stress Disorder (PTSD)
☐ Eczema (Atopic Dermatitis)	☐ Psoriasis
☐ Fibromyalgia	☐ Rheumatoid Arthritis
☐ High Blood Pressure (Hypertension)	☐ Stomach or intestinal conditions (Crohn's disease)
☐ High Cholesterol	☐ Stomach or intestinal conditions (Ulcerative colitis)
☐ Hyperthyroidism (Overactive Thyroid)	----------
☐ Other:	

Serious Past Injuries *(Describe the type of injury and approximate dates of occurrences):*

Previous Surgery	
Check off the types of surgeries you have had. *Next to the surgery, indicate the approximate date of surgery:*	
☐ Appendix:	☐ Hemorrhoids:
☐ Breast surgery:	☐ Hysterectomy:
☐ Eye surgery:	☐ Open heart surgery:
☐ Gallbladder:	☐ Stomach or colon surgery:
☐ Other surgery:	
☐ Other surgery:	

Previous Hospitalizations *(Other than surgery)*		
Hospital	**Year**	**Reason**

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Health Maintenance

Vaccines
When was your last tetanus booster?
Have you had a flu (influenza) vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known:
Have you had a pneumonia vaccine in the last 12 months? ☐ Yes ☐ No
If yes, please tell us when and where, if known:
Have you ever had a shingles vaccine? ☐ Yes ☐ No
If yes, please tell us when and where, if known:

Screenings
Do you have eye exams regularly? ☐ Yes ☐ No
Where and when was your last eye exam?
Do you have dental exams regularly? ☐ Yes ☐ No
Where and when was your last dental exam?
Have you ever had a colorectal cancer screening (colonoscopy)? ☐ Yes ☐ No
If yes, please tell us when and where, if known:

Height and Weight	
What is your height?	What is your weight?

Women's Health *(If applicable)*
Name and address of your GYN Provider:
Have you had a Pap Smear in the last two years? ☐ Yes ☐ No
Have you ever had a Mammogram? ☐ Yes ☐ No
If yes, where and when was your last scan?
Number of pregnancies:

Specialists *(List any other specialists you see – including name, location, and how often you see them.)*

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Family History

Parental Status			
Is your mother living?	☐ Yes	☐ No	Cause of death and age at death:
Is your father living?	☐ Yes	☐ No	Cause of death and age at death:

Family Health Conditions

Have any family members, either living or dead, ever had any of the following conditions? *If yes, place a checkmark on the short line next to the condition. On the line next to the condition, put the name of the family member or the initial code letter of the family member who had the illness. The following code initials may be used:*

Mother [M]	Brother [B]	Aunt [A]
Father [F]	Child [C]	Uncle [U]
Sister [S]	Grandparent [GP]	Cousin [CS]

(For example: If one of your grandparents and a cousin had tuberculosis: ☑ Tuberculosis: GP, CS)

Condition	Family Member(s)
☐ Alcoholism or substance abuse	
☐ Allergies	
☐ Asthma	
☐ Autoimmune diseases (e.g., lupus, rheumatoid arthritis)	
☐ Blood disorders (e.g., sickle cell anemia, hemophilia)	
☐ Cancer (e.g., breast, ovarian, colorectal, prostate)	
☐ Chronic respiratory conditions (e.g., chronic obstructive pulmonary disease, emphysema)	
☐ Diabetes (Type 1 or Type 2)	
☐ Genetic conditions (e.g., cystic fibrosis, Huntington's disease)	
☐ Heart disease (e.g., coronary artery disease, heart attacks)	
☐ High blood pressure (hypertension)	
☐ High cholesterol	
☐ Kidney disease	
☐ Mental health conditions (e.g., depression, anxiety, bipolar disorder)	
☐ Neurological conditions (e.g., Parkinson's disease, Alzheimer's disease, epilepsy)	
☐ Obesity	
☐ Osteoporosis	
☐ Stroke	
☐ Thyroid disorders (e.g., hypothyroidism, hyperthyroidism)	
☐ Other:	

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Contact Information

Emergency Contact Information		
Please complete all information below. In the event of an accident or other emergency, we will use this information to notify your preferred contacts:		
Primary Contact Person:		
Name:		
Date of birth:		
Relationship to patient:		
Are they a Brown Health Medical Group Primary Care patient? ☐ Yes ☐ No		
Home phone:	Cell phone:	Work phone:
Secondary Contact Person:		
Name:		
Date of birth:		
Relationship to patient:		
Are they a Brown Health Medical Group Primary Care patient? ☐ Yes ☐ No		
Home phone:	Cell phone:	Work phone:

Advance Care Planning		
Do you have an advance directive? *(Select all that apply)*	☐ Durable Healthcare Power of Attorney (DPOA)	☐ Living Will
	☐ Medical Orders for Life-Sustaining Treatment (MOLST)	☐ Five Wishes
	☐ Other:	

Signature
Patient name (Print):
Legal guardian name, if applicable (Print):
Patient (or guardian) signature:
Date:

You may update this information at any time.

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Permissions

Permission to Leave Message Containing Health Information		
I authorize Brown University Health to leave or send messages to my:		
Method	**Phone Number**	**Check all that apply**
Home phone (Voice message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical
Cell phone (Voice message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical
Cell phone* (Text message)		☐ None ☐ General/appointment reminders ☐ Detailed/clinical

**Note: By providing a telephone number and checking the appropriate box above, you are consenting to be contacted by SMS text message. Message & data rates may apply. You can reply STOP to opt-out of further messaging.*

Permission to Communicate Health Information		
All medical records are confidential. We require written authorization to discuss medical information with anyone other than the patient. By signing the authorization below, you are giving permission to discuss information contained in the medical record with another individual.		
I, _____ give the clinicians and staff of Brown University Health permission to discuss my diagnosis, procedures, and/or treatment plans with:		
Person 1	Name #1:	Relationship:
	Home phone:	Cell phone:
Person 2	Name #2:	Relationship:
	Home phone:	Cell phone:
Person 3	Name #3:	Relationship:
	Home phone:	Cell phone:
I agree and understand that my medical record contains my personal health information and may contain information that is considered sensitive under the law. Brown University Health supports integrated behavioral health, and I understand that mental health or substance use conditions may also be discussed with the above-listed individuals.		
Please note: If you have a Healthcare Power of Attorney (HCPOA), those listed above should match the Designated Health Care Agents on your HCPOA. If you have not yet provided us with a copy of your HCPOA, please fax or mail a copy of this to our practice to keep on file.		
Name:		Date of birth:
Signature:		Date:

You may update this information at any time.
For staff: Scan to patient-level / document type permission to communicate health information.

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Primary Care Provider Attestation

Clinician Confirmation
This form is to attest that the clinician indicated below is the designated primary care provider of the patient.
Primary care provider:
Patient name:
Patient DOB:
Legal guardian name, if applicable (Print):
Patient (or guardian) signature:
Date of signature:

For staff: Scan to patient-level/document type primary care PCP attestation.