QUITWORKS-RI & QBH

Tobacco use Questionnaire

1. Do you now smoke cigarettes? ___No ___Yes
   (If yes, how many cigarettes do you smoke a day? _____ cigarettes)

2. Do you use any of these other tobacco products?
   ___Pipe ___Snuff ___Chewing Tobacco ___Cigars
   (If yes, how many time a day? _____times a day)

3. Does anyone in your household smoke? ___No ___Yes

4. Do you want to stop smoking in the next month? ___No ___Yes

5. Do you want help Quitting? ___No ___Yes
   (if yes, fill out information below and give form to your provider, who will forward it to QBH Patient Care Coordinator, Beverly)

Rhode Island Patient Enrollment Form

Are you 18 or older? ☐Yes ☐No

_____ _____
First Name Last Name

_____
Mailing Address City State Zip

( ) _____
Phone Number

When Should we call ? (check all that apply) ☐Morning ☐Afternoon ☐Evening ☐No Preference

Language Preference: ☐English ☐Spanish ☐Other (specify)_____

May we leave a message? ☐Yes ☐No

Primary Insurance ☐BCBS of Rhode Island ☐United Health Care ☐Neighborhood Health Plan ☐Tufts
Of Tobacco User: ☐Medicare ☐Medicaid (check one): __RIte Care ___Connect Care ___ Rhody Health ☐Other
☐None

I authorize this provider to release the information on this enrollment form to QuitWorks so that I may be contacted and participate in the QuitWorks program. I also authorize QuitWorks to disclose information about my progress in attempting to quit smoking to the health care provider listed on this form.

_____ _____
Patient Signature Date