

# NEW PATIENT CHECKLIST

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

## Step 1: Complete Your Registration Paperwork

Fill out and sign all required forms provided to you. If you need help, let us know.

## Step 2: Tell Us About Your Preferences and Needs

Please check or fill in the information that applies to you:

- Provider gender preference:  Male  Female  No preference
- Transportation assistance needed:  Yes  No
- Communication assistance (i.e.: interpreter needed):  Yes  No
- Preferred 1st appointment day/time:

\_\_\_\_\_  
\_\_\_\_\_

- Previous primary care provider & specialists (list all):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Step 3: Turn in Your Paperwork

Please return your completed forms to a Patient Services Representative or hand them to a Patient Ambassador. We'll make sure everything is in order.

## Step 4: Request Your Medical Records

We can help you request your records from previous providers. You do not need an appointment for this step, just ask us how!



<b>PATIENT REGISTRATION FORM</b>					
FULL NAME			PREFERRED NAME		
DATE OF BIRTH (MM/DD/YY)		SSN#	GENDER AT BIRTH <input type="checkbox"/> Male <input type="checkbox"/> Female		
ADDRESS		CITY	STATE	ZIP CODE	
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)		MAILING CITY	MAILING STATE	MAILING ZIP CODE	
HOME PHONE		CELL PHONE	WORK PHONE		
ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)		LEGAL MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Partner			
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)		Employer:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> PRN <input type="checkbox"/> Student		
PHARMACY <input type="checkbox"/> Health Ministries Clinic Pharmacy <input type="checkbox"/> Other Pharmacy (specify): _____					
TRANSPORT Do you need Transportation Assistance to and from your appointments at Health Ministries Clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No					
RACE <i>(Check all that apply)</i>		HOUSING <i>Are you currently experiencing homelessness?</i>		GENDER IDENTITY*	
<input type="checkbox"/> White		<input type="checkbox"/> Yes		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Black/African American		<input type="checkbox"/> No		<input type="checkbox"/> FTM <input type="checkbox"/> MTF	
<input type="checkbox"/> American Indian/Alaska Native		<b>IF YES:</b> are you utilizing any of the following? <input type="checkbox"/> Transitional		<input type="checkbox"/> Nonbinary <input type="checkbox"/> Decline to specify	
<input type="checkbox"/> Other Pacific Islander				<input type="checkbox"/> Other (please specify): _____	
<input type="checkbox"/> Samoan		<input type="checkbox"/> Doubling Up		SEXUAL ORIENTATION*	
<input type="checkbox"/> Guamanian or Chamorro		<input type="checkbox"/> Street		<i>(Not required if under the age of 18)</i> <input type="checkbox"/> Straight or Heterosexual	
<input type="checkbox"/> Asian		<input type="checkbox"/> Other (please specify): _____		<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Vietnamese		DO YOU LIVE IN PUBLIC HOUSING?		<input type="checkbox"/> Lesbian/Gay/Homosexual	
<input type="checkbox"/> Filipino		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> I do not know	
<input type="checkbox"/> Korean		POPULATIONS <i>(Check all that apply)</i>		<input type="checkbox"/> Decline to Specify	
<input type="checkbox"/> Japanese		<input type="checkbox"/> Veteran		<input type="checkbox"/> Other (please specify): _____	
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Farm Worker (requires voucher)		PREFERRED PRONOUNS	
<input type="checkbox"/> Chinese		<input type="checkbox"/> Migrant Worker		He/Him      She/Her      They/Them	
<input type="checkbox"/> Declined to Specify		<input type="checkbox"/> Seasonal Worker		Other (please specify): _____	
DO YOU IDENTIFY AS HISPANIC/LATINO?		PREFERRED LANGUAGE		<i>*Sexual Orientation and Gender Identity can play a significant role in determining health outcomes. Please see the front desk or ask your healthcare team if you have questions about disclosing this information.</i>	
<input type="checkbox"/> No		<input type="checkbox"/> English			
<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano		<input type="checkbox"/> Spanish			
<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Interpreter Needed			
<input type="checkbox"/> Yes, Cuban		<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Yes, Other Hispanic Latino				HOW DID YOU HEAR ABOUT HMC?	
				<input type="checkbox"/> Social media <input type="checkbox"/> Flyers <input type="checkbox"/> Google	
				<input type="checkbox"/> Friend <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Check if Same as Patient <b>RESPONSIBLE PARTY</b> (PERSON RESPONSIBLE FOR PAYING ON PATIENT ACCOUNT)					
FULL NAME			SSN#		
DATE OF BIRTH		EMPLOYER	CONTACT NUMBER		
ADDRESS		CITY	STATE	ZIP CODE	

PATIENT NAME:		DOB:			
<b>INSURANCE INFORMATION (HMC WILL NEED A COPY OF YOUR INSURANCE CARD(S))</b>					
PRIMARY HEALTH INSURANCE:			SECONDARY HEALTH INSURANCE:		
HEALTH INSURANCE COMPANY			HEALTH INSURANCE COMPANY		
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):			NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE):		
GROUP #	POLICY #		GROUP #	POLICY #	
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):			POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE):		
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____			POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____		
<b>PRIMARY DENTAL INSURANCE</b>					
DENTAL INSURANCE COMPANY					
NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE)					
POLICY HOLDER'S DATE OF BIRTH (IF DIFFERENT FROM ABOVE)					
POLICY HOLDER'S RELATIONSHIP TO PATIENT <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other _____					
<b>HOUSEHOLD INCOME</b>					
<p>The following information is used to determine if you may qualify for discounted fees and services.          This information can be updated at any time.</p> <p><b>Have insurance? You still may qualify for a discount!</b></p> <p>Sliding fee scales also apply for possible discounts at the pharmacy, along with HMC appointments.</p>					
<b>Number in Household</b>	<b>Annual Household Income</b>				
	<b>Slide A</b>	<b>Slide B</b>	<b>Slide C</b>	<b>Slide D</b>	<b>No Slide: (&gt;200% of FPG)</b>
<b>1</b>	<input type="checkbox"/> < \$15,960	<input type="checkbox"/> \$15,961-\$23,940	<input type="checkbox"/> \$23,941-\$27,930	<input type="checkbox"/> \$27,931-\$31,920	<input type="checkbox"/> > \$31,921
<b>2</b>	<input type="checkbox"/> < \$21,640	<input type="checkbox"/> \$21,641-\$32,460	<input type="checkbox"/> \$32,461-\$37,870	<input type="checkbox"/> \$37,871-\$43,280	<input type="checkbox"/> > \$43,281
<b>3</b>	<input type="checkbox"/> < \$27,320	<input type="checkbox"/> \$27,321-\$40,980	<input type="checkbox"/> \$40,981-\$47,810	<input type="checkbox"/> \$47,811-\$54,640	<input type="checkbox"/> > \$54,641
<b>4</b>	<input type="checkbox"/> < \$33,000	<input type="checkbox"/> \$33,001-\$49,500	<input type="checkbox"/> \$49,501-\$57,750	<input type="checkbox"/> \$57,751-\$66,000	<input type="checkbox"/> > \$66,001
<b>5</b>	<input type="checkbox"/> < \$38,680	<input type="checkbox"/> \$38,681-\$58,020	<input type="checkbox"/> \$58,021-\$67,690	<input type="checkbox"/> \$67,691-\$77,360	<input type="checkbox"/> > \$77,361
<b>6</b>	<input type="checkbox"/> < \$44,360	<input type="checkbox"/> \$44,361-\$66,540	<input type="checkbox"/> \$66,541-\$77,630	<input type="checkbox"/> \$77,631-\$88,720	<input type="checkbox"/> > \$88,721
<b>7</b>	<input type="checkbox"/> < \$50,040	<input type="checkbox"/> \$50,041-\$75,060	<input type="checkbox"/> \$75,061-\$87,570	<input type="checkbox"/> \$87,571-\$100,080	<input type="checkbox"/> > \$100,081
<b>8</b>	<input type="checkbox"/> < \$55,720	<input type="checkbox"/> \$55,721-\$83,580	<input type="checkbox"/> \$83,581-\$97,510	<input type="checkbox"/> \$97,511-\$111,440	<input type="checkbox"/> > \$111,441
<input type="checkbox"/> More than 9+ members in household—Please ask the Front Desk for additional information					
<input type="checkbox"/> <b>*I DO NOT QUALIFY FOR THE SLIDING FEE SCALE, AND/OR CHOOSE TO DECLINE*</b> <input type="checkbox"/> <b>**I ATTEST THAT I AM ABOVE 200% OF FEDERAL POVERTY GUIDELINES (FPG)**</b>					
<b>HMC OFFICE USE ONLY</b>					
If the above patient needed help filling out this form and the patient and/or legal representative is present					
Staff Name: _____		Staff Signature: _____		Date Completed: _____	

## Patient's Rights and Responsibilities

Health Ministries Clinic (HMC) is a community health center that exists to promote and improve the quality of life by providing integrated healthcare. Each patient who entrusts HMC with their care is treated with dignity, respect, and compassion. HMC acknowledges that all patients have fundamental rights and is dedicated to honoring these rights. Every individual should be informed of the patient's rights and responsibilities before being provided care.

### PATIENT'S RIGHTS

While patients are in the care of HMC, staff is committed to respecting patient's privacy and their right to be an active partner in making decisions about their health care. Patients have a right to:

1. Be treated with courtesy, dignity, and respect with consideration for personal, cultural, psychosocial, religious, and spiritual preferences regardless of race, color, national origin, age, disability, sexual orientation, gender identity or language preference.
2. Expect communications and records pertaining to their care, including the source of payment, to be kept confidential.
3. Expect any discussions or consultations to be kept private; persons not directly involved in care are not present without patient and/or guardian's permission.
4. Effective communication that considers language needs, as well as hearing, speech and visual impairments.
5. Request information about fee schedules and payment policies.
6. Accurate and honest billing practices.
7. Request a reasonable estimate of the clinical cost of care and/or may receive one prior to treatment.
8. Have complete information about health status, diagnosis, prognosis, and treatment.
9. Receive comprehensive information to make informed treatment decisions.
10. Be respected related to the right to refuse care, treatment, or services in accordance with laws and regulations.
11. Choose a provider that aligns with treatment goals.
12. To have access to, request amendment to, and obtain information on disclosures of patient's health information, in accordance with law and regulation.
13. Express suggestions or grievances to a member of clinic management.
14. Participate in decisions about their health care, unless medically inadvisable.
15. Lawfully assign someone to exercise the rights indicated above on their behalf, if unable to exercise said rights themselves.

### PATIENT'S RESPONSIBILITIES

While you are a patient of HMC patients are expected to:

1. Provide, to the best of their knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications.
2. Report unexpected changes in their health to the nurse or provider.
3. Ask questions to achieve better understanding (treatments, procedures, medications, etc.)
4. Be considerate of other patients and clinic staff.
5. Be a partner in their care.
6. Keep scheduled appointments and/or cancel/reschedule them as early as possible to allow others a chance to be seen.
7. Inform the health care provider if they feel uncomfortable about a recommended plan of treatment.
8. Provide accurate financial and insurance information needed to determine ability to pay for services.
9. Make reasonable efforts to pay for services at the time of the visit, or according to their payment plan. If this is not possible, notify HMC.
10. Provide the information needed to help with assistive services.
11. Notify HMC about changes regarding their financial situation or health insurance.
12. Respect the rights and property of other patients, staff, and other persons within HMC facilities.
13. Know the regulations and rules that apply while a patient inside the clinic.
14. Understand that aggressive behavior (including but not limited to physical assault, verbal harassment, abusive language, sexual language directed at others, threats) can result in dismissal from HMC.

I HAVE READ AND UNDERSTAND THE POLICIES AS STATED AND AGREE TO ABIDE BY THEM.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

**PAYMENT AGREEMENT**

I agree all payments and co-payments must be paid at the time of service. I understand to be eligible for the sliding fee scale I must provide proof of income. Proof may consist of my previous tax return, paycheck stubs (3), unemployment printout, etc. This information must be provided at the time of visit for the sliding scale to be offered. I understand if my account is 90 days past due, I will receive a letter stating I have to pay on my account or I am subject for my past due account being written off to bad debt. I understand partial payments will be accepted unless otherwise negotiated.

**INSURANCE FILING**

I hereby authorize Health Ministries Clinic (HMC) to furnish information to insurance carriers concerning my illness and treatments. I understand my insurance will be filed as a courtesy and I agree to be financially responsible for any balance due to Health Ministries Clinic, Inc. I understand failure to provide HMC with current, accurate insurance information will result in all charges becoming my responsibility or responsible party. All co-pays and co-insurance fees are due at time of service. These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. I understand I will be responsible for any charges not paid by my insurance.

**MEDICARE PATIENTS**

Patients with Medicare or Medicaid, please be advised there may be an applicable co-pay for services rendered. I authorize Medicare benefits be made either to me or on my behalf to Health Ministries Clinic, Inc. for any services furnished me by Health Ministries Clinic, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**ATTENDANCE AGREEMENT**

I agree to contact HMC via phone, website or patient portal before the event that I need to cancel or reschedule my appointment. I understand all appointments (i.e., medical, dental and behavioral health) are considered a no-show if I fail to report to the clinic for a scheduled appointment. A no-show will be implemented when a patient shows for their appointment 10 minutes or more after the appointment. I understand I need to arrive 15 minutes before my appointment time, to complete the required check-in process and pay fees at the reception desk. I agree if I have two (2) no-shows within a one-year period, I will be required to meet with a Patient Care Coordinator and/or designee before scheduling another appointment. I understand if I have a third (3) no-show in a one-year period, I may be informed I will no longer have the ability to schedule future appointments or possibly be placed on "same-day scheduling" for a minimum of six (6) months. I understand if I have scheduling privileges suspended, I may request that my status be reviewed by the Chief Executive Officer and/or designee. I acknowledge I understand the expectations about the need to keep my scheduled appointment and the potential consequences if this fails to happen.

**ELECTRONIC HEALTH INFORMATION TECHNOLOGY**

HMC participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or healthcare operations. HIO's are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all of your information through an HIO (except by law). If you wish to restrict access, you must submit the required information either online at <http://www.KanHIT.org> or by completing and mailing a form. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information. If you have questions regarding HIT or HIO's, please visit <http://www.KanHIT.org>.

**PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES**

I understand that HMC provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits, should my provider utilize such services. I acknowledge that my participation is voluntary and that I may revoke this consent at any time providing HMC a 30-day written notice.

**PATIENT ACKNOWLEDGEMENT & NOTICE OF PRIVACY PRACTICES**

I acknowledge that HMC has given me the right to review and secure a copy of the Notice of Privacy Practices, which describes how health information about me may be used and disclosed, as well as a complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that HMC reserves the right to change the terms of this notice periodically, and that I may contact HMC at any time to obtain the most current copy of these documents. I understand that if I have any questions regarding any of these documents, I can contact HMC. A paper copy may be obtained at the reception desk.

**I hereby acknowledge that I have read, fully understand, and accept the terms of the financial guidelines and policies stated above.**

**PATIENT AUTHORIZATION & CONSENT**

- I consent that I am presenting to HMC for examination, diagnosis and/or treatment of my medical, dental, or behavioral health condition.
- I give consent and authorize my provider/clinician(s) or designees to order and/or perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my medical, dental or behavioral health condition.
- This consent is valid for any visit I make to HMC unless revoked by me in writing.

PATIENT NAME (PRINTED)

PATIENT DOB:

PATIENT OR PARENT/GUARDIAN SIGNATURE:

DATE:

Patient or Parent/Guardian refuses to acknowledge Notice of Privacy Practices

## Patient Communication Authorization

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize Health Ministries Clinic (HMC) to share my personal health information with the listed representative(s) below. I understand this authorization is voluntary. I understand that once information is disclosed, it may be disclosed by the third party(s), and the information may not be protected by Federal Privacy Laws or Regulations. I understand this consent will remain in effect until I request an update. This Authorization is for use, pursuant to the HIPPA Privacy Rules, if you are authorizing the release of medical/health information to another individual for access on an on-going basis to assist with your care and maintaining your information. You understand these records may contain information created by other persons or entities, including physicians and other health care providers as well as information regarding **the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services (excluding psychotherapy notes), reproductive health services, and treatment for sexually transmitted diseases.** You have the right to revoke this authorization at any time in person at HMC. The revocation is only effective after it is received and logged. Any use or disclosure made prior to a revocation is not included as part of the revocation. The purpose of this form is for HMC to communicate the patient's healthcare information to a 3<sup>rd</sup> party listed below. **This form expires one year from the date of signature unless revoked beforehand.**

**IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A VOICE MESSAGE?**

No, do not leave a voice message

Yes, please leave a voice message

**IF YOU ARE NOT AVAILABLE, WHO MAY WE COMMUNICATE WITH? PLEASE CHECK ALL THAT APPLY.**

**Communicate with SELF ONLY**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

\*By selecting consent to treat, I, as the parent or guardian\*\* of the minor aged patient agree to allow the following persons checked above to give consent to the treatment of said minor.

\*\*Legal guardians please bring your paperwork noting your relation to the minor, if applicable

\*\*\*Additional authorized individuals may be listed on the reverse side of this form

\_\_\_\_\_  
**Patient or Parent/Guardian Name Printed**

\_\_\_\_\_  
**Patient or Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Parent/Guardian Name Printed**

\_\_\_\_\_  
**Patient or Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Parent/Guardian Name Printed**

\_\_\_\_\_  
**Patient or Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

## Additional Communication Authorization

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Any Information   | <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Pharmacy            | <input type="checkbox"/> Consent to treat minor patient*<br>(For patients under the age of 18) |
| <input type="checkbox"/> Emergency Contact | <input type="checkbox"/> Test Results            | <input type="checkbox"/> Billing Information |  |

## HEALTH HISTORY (CONFIDENTIAL)

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  

Last Name
First Name
Middle Name

Primary Care Provider: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Medical History** (Check conditions you have or have had in the past)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia                                      | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Eating Disorder         |
| <input type="checkbox"/> Arthritis                                   | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Depression/Anxiety      |
| <input type="checkbox"/> Asthma                                      | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Thyroid issues              | <input type="checkbox"/> Drug Addiction          |
| <input type="checkbox"/> Diabetes                                    | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Alcoholism              |
| <input type="checkbox"/> Emphysema                                   | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Dementia/memory loss        | <input type="checkbox"/> AIDS/HIV Positive       |
| <input type="checkbox"/> Epilepsy                                    | <input type="checkbox"/> Rectal Bleeding    | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Suicide Attempt         |
| <input type="checkbox"/> Gout  | <input type="checkbox"/> Prostate Problems  | <input type="checkbox"/> Organ transplant            | <input type="checkbox"/> Domestic Violence       |
| <input type="checkbox"/> Hernia                                      | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Artificial Heart Valves     | <input type="checkbox"/> Cancer of _____         |
| <input type="checkbox"/> Chest Pain                                  | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Received blood transfusion  | <input type="checkbox"/> Mental Condition: _____ |
| <input type="checkbox"/> Hepatitis                                   | <input type="checkbox"/> Tuberculosis (TB)  | <input type="checkbox"/> Bleeding Disorder           | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Stroke                                      | <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Osteoporosis-If yes, list medication: _____ |   |  | <input type="checkbox"/> Other: _____            |

**Medication(s):**

List all medications, prescription & non-prescription	Dosage	Frequency

**Allergies**      **ARE YOU ALLERGIC TO LATEX?**   No   Yes   If yes, reaction \_\_\_\_\_

Allergy (Medication or Environmental)	Reaction

**Gynecological History**

Age your menstrual cycle began: \_\_\_\_\_ Date of last menstrual cycle: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Last Pap Smear: \_\_\_\_\_ Result: \_\_\_\_\_  
 Date of Last Mammogram: \_\_\_\_\_ Result: \_\_\_\_\_

List any gynecological problems in past (i.e., endometriosis, breast lump, irregular periods, heavy bleeding, chronic pelvic pain) \_\_\_\_\_

**Obstetrical History** (Please fill out for each pregnancy even if it was a miscarriage or abortion.)

Type of Delivery (Miscarriage, Abortion, Vaginal Delivery, C-Section)	Date	Complications	Age

**Surgical & Hospitalization History**

List Type of Surgery or Reason for Hospitalization	Month/Year of Surgery

**Family Medical History** (Please fill in health information about your family and check if your family has been diagnosed or treated for the following)

Relation	Age	State of Health	Age of Death	Cancer	Diabetes	Hypertension	Heart Disease	Thyroid Disease	Lung Disease	Other
Father										
Mother										
Daughter										
Son										
Siblings										

**Social History**

Tobacco Use     Yes  No  Former    Type: \_\_\_\_\_    #Years: \_\_\_\_\_    # cigarettes/day: \_\_\_\_\_

How soon after waking up do you smoke: \_\_\_\_\_    Interested in quitting tobacco:  No  Yes  Thinking about it

Passive Tobacco Exposure     Yes  No

Illicit Drug Use     Yes  No  Former    Type: \_\_\_\_\_    #Years: \_\_\_\_\_    Amt/day: \_\_\_\_\_    Yr. Quit: \_\_\_\_\_

Alcohol Use     No  Daily  Weekly  Monthly  Socially    How many drinks per occasion: \_\_\_\_\_

Sexually active     Yes  No - Any Sexually Transmitted Disease in the past? If yes, specify: \_\_\_\_\_

Caffeine Intake     Tea  Soda  Coffee    # of cups per day: \_\_\_\_\_

Exercise     2-3x/week  Daily     Occasional  Never

**Immunizations**

Tdap <input type="checkbox"/> I have received a vaccine for Tdap	Hep B <input type="checkbox"/> I have received the Hepatitis B vaccination series
Flu <input type="checkbox"/> I have received the Flu vaccine this year	Shingles <input type="checkbox"/> I have received the Shingles 2-series vaccination
Covid <input type="checkbox"/> I have received the Covid vaccine	Pneumonia <input type="checkbox"/> I have received a vaccine for Pneumonia

 \_\_\_\_\_  
 Patient/Guardian (Print name)

 \_\_\_\_\_  
 Relationship

 \_\_\_\_\_  
 Patient/Guardian (Signature)

## PEDIATRIC HEALTH HISTORY (CONFIDENTIAL)

 \_\_\_\_\_  
 Patient Name

 \_\_\_\_\_  
 DOB

 \_\_\_\_\_  
 Date Completed

### GENERAL

 Do you consider your child to be in good health?  Yes  No  Don't Know Explain: \_\_\_\_\_

 Does your child have any special health care needs?  Yes  No  Don't Know Explain: \_\_\_\_\_

 Do you have any concerns about your child's health or development?  Yes  No  Don't Know

If yes, please explain: \_\_\_\_\_

### BIRTH HISTORY

Birth weight: \_\_\_\_\_ Weeks at Delivery: \_\_\_\_\_ (ex:37 weeks 2 days)

 Delivery:  Vaginal  Cesarean Reason: \_\_\_\_\_

How old was the mother when the child was born: \_\_\_\_\_ Which pregnancy was this child for the mother: # \_\_\_\_\_

 Any complications during birth or after birth:  No  Yes Explain: \_\_\_\_\_

 Did the baby need to go to the NICU (neonatal intensive care unit)?  No  Yes Explain: \_\_\_\_\_

#### During pregnancy, did the mother:

 Take prenatal vitamins?  Yes  No  Unknown

 Smoke or use e-cigarettes?  Yes  No  Unknown

 Drink alcohol?  Yes  No  Unknown

 Use marijuana?  Yes  No  Unknown

 Use illegal drugs?  Yes  No  Unknown

 Take other medications?  Yes  No  Unknown

If yes, please list: \_\_\_\_\_

Blood Type: Mother: \_\_\_\_\_  Unknown

 Baby: \_\_\_\_\_  Unknown

#### Mother's Lab Results:

#### After birth, did the baby get:

 Group B streptococcus (GBS)  Pos  Neg  Unknown

 Vitamin K shot?  Yes  No  Unknown

 Hepatitis B:  Pos  Neg  Unknown

 Erythromycin eye ointment?  Yes  No  Unknown

 Hepatitis C:  Pos  Neg  Unknown

 Hepatitis B shot?  Yes  No  Unknown

 HIV:  Pos  Neg  Unknown

 RPR (Syphilis):  Pos  Neg  Unknown

 Did baby go home with biological mother from hospital after birth?  Yes  No  Explain: \_\_\_\_\_

**IMMUNIZATION HISTORY** (please provide a copy of your child's past immunization history)

 Are immunizations up to date?  Yes  No, specify: \_\_\_\_\_  Decline Immunization

**HOSPITALIZATION**  no past hospitalization

Age/Dates	Reason for Hospitalization

**SURGICAL HISTORY**  no past surgical history

Age/Dates	Type of Surgery	Reason for Surgery

**SOCIAL HISTORY** please list all those living in the child's home

Name	Relationship to Child	Age

Please list other siblings not living in the home

Name	Where are they living?	Age

Does the child live with both biological parents?  Yes  No (If you marked YES, skip the next two questions)

If no, what is the child's current living situation?  Single-parent custody  Joint custody  Adoptive family  
 Other family members: \_\_\_\_\_  Foster care

How often does the child have visitation with parent(s) not living in the home? \_\_\_\_\_

Parent place of work: Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Pets: Do you have an pets in the home?  Yes  No Number of pets in the home: \_\_\_\_\_

What kind of pets? \_\_\_\_\_

Smokers in the home: Are there any smokers in the home?  Yes  No Smoke outside only?  Yes  No

School: If school age: Grade: \_\_\_\_\_ School: \_\_\_\_\_

**ALLERGIES**  no allergies

List all reactions to medicine, foods, and other agents:

Allergy	Reaction	Side Effects

**MEDICATION LIST**  not taking any medications

Please list all the medications your child is taking/takes on a routine basis. You may use the last page if needed.

Medication	Dose/Frequency	Reason for taking

**SPECIALITY PROVIDERS**  no specialists involved in my child's care

Please list any medical providers the child sees outside of this practice.

Doctor's Name	Specialty/Reason for seeing them	When did you last see this specialist? (Month/Year)

## FAMILY HISTORY

Have any immediate family members passed away from medical conditions that may be relevant to your health? If yes, please include their relationship, cause of death (if known), and age at death:

Relation to Family Member	Cause of Death/Medical Condition	Age

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK= Don't Know

Condition	Yes	No	DK	Details/Specify Family Member-Relation
Anemia or bleeding problems				
Asthma				
Allergies				
Cancer				
Depression or anxiety				
Developmental Disability				
Diabetes (please specify if Type I or Type II)				
Heart attack (myocardial infarction) or heart disease				
High blood pressure				
High cholesterol				
HIV or AIDS				
Kidney or Liver Disease				
Mental health conditions				
Obesity				
Seizures or epilepsy				
Stroke				
Sudden death (before age 50 years)				
Thyroid or other endocrine disease				
Tobacco, Substance Abuse, or Alcohol use problems				
Tuberculosis				
Vision or eye problems				

## PATIENT PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK= Don't Know

Condition	Yes	No	DK	Details
ADHD, anxiety, depression, or mood/behavior problems				
Anemia, bleeding problems, or blood transfusions				
Asthma, wheezing, or breathing problems				
Bed-wetting (after 5 years old)				
Bone, joint, or muscle problems				
Bronchitis, bronchiolitis, or pneumonia				
Cancer, chemotherapy, bone marrow or organ transplant				
Chickenpox or zoster (Shingles)				
Concussion or head injury				
Constipation needing medical treatment				
Convulsions, seizures, or neurological issues				
Developmental delays (speech or motor)				
Eye problems, cataracts, vision impairment or concerns				
Feeding issues or underweight				
Females: issues with periods? Age of first period: _____				
Frequent ear infections				
Frequent headaches or dizziness				
Frequent stomach pain				
Hearing loss or concerns				
Heart murmur or other heart problems				
Kidney, urinary tract infections, bladder, liver problems				
Metabolic/genetic disorders				
Serious injuries or fractures (broken bones)				
Sexually transmitted infections, HIV or AIDS				
Skin rashes, acne, eczema, or hives				
Sleep problems or snoring				
Thyroid, Diabetes, or other endocrine problems				
Tobacco, alcohol, or drug use				

Other medical problems:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or clinic staff responsible for any errors or omissions that I may have made in completing it.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Guardian

\_\_\_\_\_  
Date Relationship

### HMC OFFICE USE ONLY

This section is to be filled out by HMC staff. IF, the above patient needed help filling out this form and the patient and/or legal representative is present.

\_\_\_\_\_  
Staff Name

\_\_\_\_\_  
Date Completed