Patient Registration Form

This form is for new patients or patients that have not been seen by a provider in more than two years. You will need to complete this form in its entirety before your first appointment.

Patient Demographics

Match ID Provided	Last Name	First Name	Middle Name	Sex (at Birth) ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Soc Security #
Alternate Name						
In case of a minor (18 years or less)	Parent/Guardian Full Name: ______________________________ Relationship: ___________ Parent: Guardian DOB: ___/___/_____					
	Parent/Guardian Full Name: ______________________________ Relationship: ___________ Parent: Guardian DOB: ___/___/_____					
Address	Street Address		City	State	Postal/Zip Code	
Contact Info	Home Phone	Cell Phone	Alternate Phone	Email		
Emergency Contact	Last Name	First Name	Cell Phone	Relationship to Patient		
Preferred Pharmacy If Left blank will be assigned to HFHC						

Insurance Information (Insurance Card is Required at every visit)

☐ Patient has NO insurance

☐ Patient has Private Medical Insurance		☐ Patient has a Secondary Medical Insurance		☐ Patient has a separate Dental Insurance	
Insurance Company Name:		Insurance Company Name:		Insurance Company Name:	
Employer:		Employer:		Employer:	
Policy Holder's Name:		Policy Holder's Name:		Policy Holder's Name:	
Policy Number#		Policy Number#		Policy Number#	
Policy Holder's Date of Birth:		Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
Relationship to Patient	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	Relationship to Patient	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	Relationship to Patient	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian

Responsibility for Payment & Assignment of Benefits: I assign to HFHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers, and other third parties who are financially liable for the medical care and treatment provided by HFHC. I agree that, except as may be limited by law or HFHC'S agreements with third-party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at HFHC facilities under the rates and terms of HFHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles. I understand that payment in full is expected on a timely basis.

Print Name: ________________________________

Signature: ________________________________

Relationship to Patient:
☐ Self ☐ Legal Custodian
☐ Natural Guardian (Parent) ☐ Legal Guardian

Date: ___/___/_____

Patient Name: ____________________

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SOCIAL QUESTIONNAIRE

Primary Language

Please indicate your preferred language: ______________________

- ☐ My child will need a language translator during the medical visit.
- ☐ My child is hearing impaired or will need SIGN Language interpreter services.

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Life Partner
- ☐ Widow
- ☐ Legaly Separated

Race

- ☐ I choose not to disclose my race.
- ☐ More than one race
- ☐ White
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native American
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ African American/Black
- ☐ American Indian or Alaska Native
- ☐ Guamanian or Chamorro
- ☐ Other: ______

Ethnicity

- ☐ I choose not to disclose my ethnicity.
- ☐ Not Hispanic, Latino/Latina, or Spanish Origin
- ☐ Mexican,
- ☐ Mexican-American, Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/Latina, or Spanish Origin
- ☐ Other: _________

Sexual Orientation

- ☐ I choose not to disclose my sexual orientation
- ☐ Straight
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Other: ___________

Gender Identity

- ☐ I choose not to disclose my sexual gender identity
- ☐ Male
- ☐ Transgender Male
- ☐ Female
- ☐ Transgender Female
- ☐ Other: __________________________

Preferred Pronouns

- ☐ I choose not to disclose my pronouns.
- ☐ He/him
- ☐ She/her
- ☐ They/them
- ☐ Other: ________________________________

Alternate Housing (if applicable)

- ☐ Homeless (outdoors, street)
- ☐ Homeless Shelter (overnight housing)
- ☐ Doubling up (living with others)
- ☐ Transitional Housing (those transitioning from homelessness)
- ☐ Permanent Supportive Housing (service home Ex. Disabling Condition)

Special Populations

- ☐ I am a U.S. veteran
- ☐ I am a migrant farmworker
- ☐ I am a seasonal farmworker

Advance Directives:

- ☐ I have an ADVANCE DIRECTIVE DOCUMENT indicating how I want medical decisions to be made for me if I am unable to make them myself.

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CONSOLIDATED CONSENT FORM

I, ______________________________ acknowledge by checking each box that I have read and/or been given a copy of the following documents upon requests:

- ☐ Patient Centered Medical Home Guidelines
- ☐ Appointment Guidelines
- ☐ Notice of Privacy Practices
- ☐ Financial Practice and Procedures
- ☐ Patient Bill of Rights & Responsibilities
- ☐ Healthcare Advanced Directives: The Patient's Right to Decide

CONSENT TO TREAT & INFORMATION RELEASE

As a Federally Qualified Health Center, HFHC. is covered by the Federal Tort Claims Act.

1. I authorize HFHC and its medical, dental, nursing, and other healthcare staff to provide medical services and administer diagnostic, emergency, and therapeutic procedures and treatments deemed necessary or advisable by the medical, dental, or clinical staff of HFHC. This includes all routine medical and dental screening and diagnostic tests and procedures, including the administration and/or injection of pharmaceutical products, immunizations and medications, blood withdrawal for laboratory tests, radiology, behavioral health services, referrals, external prescription information, telehealth, and case management, unless specifically declined.
   I decline the following services: ____
   ____
2. I acknowledge that no guarantees have been provided to me regarding the outcomes or efficacy of the treatments or examinations administered. I am aware of my right to refuse consent for any suggested care, treatment, test, surgery, or procedure, or to withdraw previously given consent. If my medical condition exceeds the capabilities of HFHC services following evaluation, I will be directed to alternative resources.
3. I authorize HFHC to disclose the necessary immunization information to schools for admission purposes as required by law, and to the following: Social Security, the Centers for Medicare and Medicaid or their intermediaries (Medicaid/Medicare), or any other insurance company for billing purposes.
4. I authorize HFHC. to release to my insurance carrier and its agents any information concerning health care, advice, treatment, supplies provided, or supplies needed to determine these benefits or the benefits payable for related services.
5. I authorize the provider to take X-rays, study models, photographs, or any other diagnostic aids they consider appropriate to complete a thorough diagnosis of the patient's needs. I also understand that all X-rays and diagnostic aids are the property of HFHC and that requested copies will be made available for a reasonable fee as allowed by law.
6. I also give permission to the provider to select and use assistance as they see fit. I understand that using local anesthetics carries some potential risk.
7. I understand that I may receive messages from HFHC via telephone, text, and email, and that I may opt out of messages at any time by notifying an HFHC team member. Standard text and data rates may apply.
8. I authorize HFHC to use and disclose my health/prescription information to provide for, arrange or coordinate my health care treatment, enable HFHC to obtain payment for the services it provides to me, and permit HFHC to carry out ordinary health care and business operations.

I certify that I have read and understood this consent and that I have had the opportunity to ask questions. This consent will remain fully effective until it is revoked in writing.

Print Name: ________________________________

Signature: ________________________________

Relationship to Patient:

- ☐ Self
- ☐ Natural Guardian (Parent)
- ☐ Legal Custodian
- ☐ Legal Guardian

Date: ___/___/_____

Patient Name: ______________________

Authorization for Release of Personal Health Information

You may choose to let family members and friends have access to information about your medical care. Except as permitted by federal law, we will not disclose any information to anyone other than the individuals you authorize below. The information that can be shared with these authorized individuals may include details about appointments (such as dates, location, times, provider, and reason), treatments (including prescriptions, medication refills, diagnosis, and procedures), test and procedure results, as well as billing and payment information.

Name of Authorized Person	Phone Number	Relationship
Name of Authorized Person	Phone Number	Relationship
Name of Authorized Person	Phone Number	Relationship

___________ *(initial) I authorize HFHC to disclose my personal health information to the persons named above. I understand that I can revoke this authorization at any time. I understand the revocation will not apply to information already released in response to this authorization. I further understand that authorizing the release of my health information is voluntary. I can refuse to designate anyone to assure treatment. I understand that I may inspect or request a copy of the information to be released as provided in C.F.R. 164.524. I understand any release of information carries with it the potential for re-release by the recipient. Once authorized to be removed, the federal confidentiality rules may not protect the information.*

Print Name: ___________________________________

Signature: ___________________________________

Relationship to Patient:

- ☐ Self
- ☐ Natural Guardian (Parent)
- ☐ Legal Custodian
- ☐ Legal Guardian

Date: ___/___/_____

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Patient Medical History (please X all that apply)

- ☐ Asthma
- ☐ Allergies or Skin Rash
- ☐ Blood Disorders (e.g., Anemia, Sickle Cell Anemia)
- ☐ Cancer (e.g., Leukemia)
- ☐ Cardiovascular Issues (e.g., Heart Trouble, Shortness of Breath, Rheumatic Fever, Heart Murmur, Pacemaker/Artificial Heart Valves)
- ☐ Diabetes or Excessive Thirst
- ☐ Developmental Issues (e.g., Developmental Delays, Autism, ADHD)
- ☐ Emotional or Mental Health Issues
- ☐ Epilepsy or Seizures
- ☐ Eye Problems (e.g., Glasses/Contacts)
- ☐ Gastrointestinal Issues (e.g., Bowel Issues/Constipation)
- ☐ Hearing Issues (e.g., Hearing Aids)
- ☐ Hepatic Issues (e.g., Liver Problems or Hepatitis)
- ☐ Immune System Issues (e.g., AIDS/HIV Positive, Organ Transplant, Immunosuppression)
- ☐ Infectious Diseases (e.g., Tuberculosis, Sexually Transmitted Disease)
- ☐ Kidney/Renal Issues or Excessive Urination
- ☐ Neurological Problems (e.g., Stroke, Fainting, Dizzy Spells, Neurological Disorders)
- ☐ Orthopedic Issues (e.g., Spine Disorders, Painful or Swollen Joints)
- ☐ Premature Birth
- ☐ Pulmonary Issues (e.g., Pneumonia)
- ☐ Reproductive Health Issues (e.g., Currently Pregnant - if yes, specify trimester) Skin Conditions (e.g., Eczema)
- ☐ Substance Abuse (alcohol, inhalants, drugs)
- ☐ Thyroid Problems
- ☐ Transfusion History (e.g., Blood Transfusions)
- ☐ Urinary Issues (e.g., Bladder Problems)
- ☐ Taking Bisphosphonates (Bone Hardener)
- ☐ Dental Problems (e.g., Toothaches, bleeding gums, temporomandibular joint- TMJ)
- ☐ Other (Please explain): ____

Patient Current Medications (vitamins, inhalers, prescriptions, other)

Medication	Dose	Amount Taken	Times Per day	Medication	Dose	Amount Taken	Times Per day
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Patient Allergies

☐ **YES – Please list below:**

Food:

Medications: (Indicate if the patient has side effects to local anesthetic, penicillin, or any drugs/pills):

Insects:

Seasonal:

Animals:

☐ **NO KNOWN ALLERGIES**

Immunization History

Has the patient had a reaction to any immunizations/shots? If YES, please explain reaction:

What immunization/shot caused reaction:

Patient Hospital/Surgery History

Past Hospital Stays:	☐ YES	☐ NO	Explain:
Past Surgeries:	☐ YES	☐ NO	Explain:
ER visits in past year:	☐ YES	☐ NO	How Many:

Family History (please X all that apply) and list who has the problem next to it (mom, dad, grandparent, brother, sister)

☐ Anemia		☐ Stroke		☐ Heart disease	
☐ High blood pressure		☐ Diabetes		☐ Seizures	
☐ SIDS/sudden infant death		☐ Aids/HIV		☐ Sickle cell	
☐ Asthma		☐ Cancer		☐ Tuberculosis/TB	
☐ Headaches/Migraines		☐ Arthritis		☐ Dental issues (Gum Disease, Cavities or Weak Teeth)	
☐ Alcohol / drug abuse		☐ High cholesterol		☐ **Other:**	

Annual Update Needed

Patient Name: ________________________