New Patients

Information Needed to Complete a Chart

1. **PATIENT REGISTRATION FORM**
    a. General Information

2. **SIGNATURE HIPAA**
    a. Privacy Policy brochure

3. **SIGNATURE A.O.B./R.O.I.**
    a. Assignment of Benefits (insurance information)
    b. Release of Information (in case of referrals)

4. **INSURANCE INFORMATION**
    a. Medicaid/Medicare/Private Insurance/Workman's Compensation/Motor Vehicle

To be qualified for direct services offered through the Tribal Health Department you will need to provide proof or copies of:

1. **TRIBAL ENROLLMENT**
    a. Certificate of Indian Blood (CIB) or other verifiable Tribal document from a Federally recognized Tribe acknowledging membership or descent
2. **GOVERNMENT ISSUED PHOTO ID**
    a. Driver's license, passport, other

To be qualified for all services offered through the Tribal Health Department, including PRC funds, you will need to provide proof or copies of :

1. **TRIBAL ENROLLMENT**
    a. Certificate of Indian Blood (CIB) or other verifiable Tribal document from a Federally recognized Tribe acknowledging membership or descent

2. **GOVERNMENT ISSUED PHOTO ID**
    a. Driver's license or other government-issued photo ID such as a passport

3. **BIRTH CERTIFICATE/PATERNITY PAPERS-AFFIDAVIT**

4. **SOCIAL SECURITY CARD**
    a. To verify social security number

5. **PROOF OF RESIDENCY**

Southern Ute Health Center (970) 563-4581

Fax# (970) 563-0206

SOUTHERN UTE HEALTH CENTER
PO BOX 899
IGNACIO, CO 81137
(970) 563-4581

Dear Prospective Patient,

We would like to welcome you to the Southern Ute Health Center. The Southern Ute Health Center is an outpatient facility, opened October 1978, replacing the Indian Health Services Clinic, which had served the reservation since 1955. The Health Center provides comprehensive clinical and community health services to members of the Southern Ute Indian Tribe as well as members of other federally recognized tribes residing in the area. Inpatient and specialty services are also available via purchased/referred care (PRC) referrals. Contact the referral services office to determine your eligibility for purchased/referred care services.

The Health Center does NOT provide emergency services. Patients with emergencies occurring outside of regular business hours should call 911. Patients with urgent (non-emergent or non-life threatening) medical needs occurring outside of regular business hours may reach the triage nurse by contacting our main phone number (970) 563-4581, or toll free (877) 215-9635.

This package includes the following: 1. Patient Information Form, 2. Health Summary Questionnaire, 3. Patient Eligibility, 4. Release of Information, 5. Assignment of Benefits, 6. Privacy Act Form, 7. Notice of Privacy Practices, 8. Notice of Privacy Practices Acknowledgement Form, 9. Consent of Parent or Legal Guardian or Other Person Who Has Primary Responsibility for the Care of a Child. If you areeligible for Medicare, you are required to complete the Medicare Secondary Payer Questionnaire.

When an initial visit is authorized and in cases where eligibility is not in question, but proof of certification is lacking, a thirty-day grace period may be granted. If proof is not provided within thirty (30) days, no further services will be provided.

An individual must apply for and use all available and/or accessible resources including but not limited to:

- Medicare
- Medicaid
- Other state or federal health programs
- Veterans Administration (VA)
- Private Insurance

Please see the following page for further information on Alternate Resources.

Please feel free to share with us any questions, concerns, or suggestions you may have. It is our hope that by working together we can achieve the optimal level of healthcare for you, your family, and for all we serve.

Respectfully Yours,

Southern Ute Health Center Staff

Alternate Resources

The Southern Ute Health Center (SUHC) and Southern Ute Indian Tribe (SUIT) policies require that you apply for and use alternate resources for which you are eligible. Alternate Resources are other sources of health care or health care benefits such as the First Health Colorado (Medicaid), Market Place, Medicare, Private Insurance, Veterans Insurance etc. Alternate Resources pay for and can be a source of health care services that SUHC is unable to provide. The use of Alternate Resources enables SUHC to provide more health care services to our patients. All patients eligible for the Health First Colorado plan, Market Place, or Medicare Savings Programs/Limited Income Subsidies (LIS) are required to apply and show proof of acceptance or denial. If denied, patients must reapply every 6 months.

Assistance with alternate resource applications is available through the Health Benefits Coordinators.

First Health Colorado (Colorado Medicaid)

The following documents are required when applying for the First Health Colorado Plan:

Household members, social security number, employer, and income information for everyone in the home, tribal affiliation.

You can apply for Colorado Medicaid online at: **Colorado.gov/PEAK**

You can apply for New Mexico Medicaid online at: **https://www.yes.state.nm.us/**

Market Place Plan

The following is required when applying for the Market Place Plan: Same as First Health Colorado, Internet with valid Email address

Assistance with applying for Alternate Services

Please contact the health benefits coordinator for assistance with applying for alternate health services: 970-563-2203.

I understand that under federal law, I have a responsibility to apply for and maintain any Alternate Resources that I qualify to receive and that failure to comply can result in the loss of access to and payment for health services that the SUHC offers. I understand that I will not be able to receive services with the SouthernUte Health Center, Pharmacy, Dental, Optometry and Audiology and, my chart will be inactivated and if I fail to apply.

Signature (Parent or Guardian if Minor): Date:

Southern Ute Health Center
69 Capote Drive
Ignacio, CO. 81137
(970) 563-4581

Date: _____
HRN # _____

DEMOGRAPHIC INFORMATION

Name: (Last)_____ (First)_____ (Middle)_____

Is this your legal name? Yes ____ No ____ If not, what is your legal name?_____

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Date of Birth: _____ Place of Birth: _____

Social Security No: _____ Gender: Female ____ Male _____

Mailing Address:_____ City: _____ State_____ ZIP _____

Physical Address:_____ City: _____ State_____ ZIP _____

How long at this address? _____ Religious Preference: _____

Home Phone: _____Cell Phone:_____ Work/Other Phone: _____

Internet Access? Yes ____ No ____ Where? Home ___ Cell ___ Work ___

Email Address: _____

Do we have permission to email you surveys? Yes ____ No ____

Do you have an advanced directive? Yes ____ No ____ If yes, please provide a copy.

If yes, is it a : Power of Attorney _____ Living Will _____

If no, would you like information about advanced directives? Yes ____ No ____

What is your ethnicity? _____ Race? _____

Primary language spoken in the home? _____

Tribal Information

Are you enrolled in a federally recognized tribe? Yes ____ No ____

If no, are you a descendent? Yes ____ No ____

If yes, where are you enrolled (Tribal Affiliation)?_____

Employer Information

Occupation: _____ Employer: _____

Employer Address:_____ City: _____ State_____ ZIP _____

Mother's Information

MAIDEN Name: First_____ Middle _____ Last _____

Where was she born? City _____ State ____ Where is she enrolled? _____

Employer: _____Work Number:_____

Employer Address: _____ City/State/Zip:_____

What number(s) can mother be reached?_____

Father's Information

Name: First_____ Middle _____ Last _____

Where was he born? City _____ State ____ Where is he enrolled? _____

Employer: _____Work Number:_____

Employer Address: _____ City/State/Zip:_____

What number(s) can father be reached?_____

Spouse Information

Name: First_____ Middle _____ Last _____

Employer: _____Work Number:_____

Employer Address: _____ City/State/Zip:_____

What number(s) can spouse be reached?_____

Emergency Contact

Name:_____ Relationship:_____

Address:_____ Phone Number: _____

Next of Kin – Separate from Emergency Contact

Name:_____ Relationship:_____

Address:_____ Phone Number: _____

Military Service

Have you ever served in the United States Military? Yes ___ No ___

If yes, list the branch, dates, and type of discharge for all active duty.

Branch	From: MM/DD/YYYY	To: MM/DD/YYYY	Type of Discharge

Contract Health Service

I understand that I am required to provide proof of residency, meet medical priority requirement, exhaust all alternate resources, and meet notification requirements to be eligible for contract health services with the Southern Ute Tribal Health Department

ANY FALSIFICATION OF INFORAMTION MAY BE REASON FOR DENIAL OF SERVICES OR ELIGIBILITY

Patient, Parent, or Legal Guardian Signature:_____

Date:_____

Patients under 18 years of age must be accompanied by a parent or legal guardian to be seen for medical appointments.

Benefits Coordinator General Questionnaire

Do you currently have insurance coverage? Yes _____ No _____ If yes, which ones:

Medicaid:_____ Medicare:_____ Private Insurance:_____ VA:_____

Worker's Compensation:_____ Motor Vehicle:_____

Insurance:_____ Policy number:_____ Group Number:_____

Insurance:_____ Policy number:_____ Group Number:_____

Insurance:_____ Policy number:_____ Group Number:_____

Are there any children in the home under the age of 18 (19 if full-time student) who does not have health insurance? Yes _____ No _____

Have you applied for Medicaid and been denied? Yes _____ No _____ If yes, please provide denial letter.

Would you like help applying for Medicaid? Yes _____ No _____ If yes, how can we contact you?

_____

Are you 65 years of age or older? Yes _____ No _____

If yes, do you have Medicare? Yes _____ No _____

Would you like information on Medicare Part D (Pharmacy)? Yes _____ No _____

Are you disabled? Yes _____ No _____

If yes, have you applied for disability? Yes _____ No _____

If yes, what is the status of your application? Approved_____ Denied _____ Unknown ___

The information provided is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician or group. I understand that I am financially responsible for any balance. I also authorize the Southern Ute Tribal Health Department and its divisions or insurance company to release any information required in the processing of my claim.

Patient/Guardian Signature:_____ Date:_____

Health Center Review (OFFICE USE ONLY): Approved _____ Denied _____

Health Center Office Signature:_____ Date:_____

Patient Eligibility

Patients **MUST** provide proof of eligibility at the time of visits at the Southern Ute Health Center. When an initial visit is authorized and in cases where eligibility is not in question, but proof of certification is lacking, a 30-day grace period will be granted.

Examples of Proof of Eligibility:

1. Certificate of Indian Blood issued by the Bureau of Indian Affairs or the US Department of the Interior.
2. Proof of descendent or a copy of parent's Certificate of Indian Blood will cover minors up to 18 years of age.
3. Letter from enrolling Tribal Office or BIA Agency showing recognition of decadency.

If proof is not provided within the 30-day grace period, the patient will be sent two reminders, each reminder will be sent in 30-day increments. If documentation is not providedafter the 90 days, the patient will be inactivated and may be billed for the health care servicesprovided.

I have read and understand the above statements:

Signature of Patient	Date
Patient Registration Clerk Signature	Date Informed
Patient Registration Clerk Signature	Date of Reminder #1
Patient Registration Clerk Signature	Date of Reminder #2

Release of Information and Assignment of Benefits

Authorization for Health Care

The undersigned voluntarily agrees to treatment and services that his or her physician deems necessary.

Release of Information for Treatment and Billing Services

I understand and acknowledge that the SUHC may release information to other providers for the provision, coordination, or management of my health care and related services. The SUHC may disclose all or any reasonable part of the patient's medical record to include information pertaining to medical history, mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the health care charges to include but not limited to any person, insurance companies, employer, preadmission review, utilization review, evaluation, financial audit, or any other purposes. I understand that this authorization will remain in effect as long as health care services are rendered.

Private Insurance

The Southern Ute Health Center (SUHC) may disclose all or any part of the patient's records to any person or corporation which is, or may be, liable under a contract to the health clinic, the patient, a family member and/or employer of the patient for all or part of the health clinic's charges, including, but not limited to, the health clinic or medical services companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

I hereby assign to SUHC such insurance benefits, if any that I may have pertaining to payment for medical services and supplies furnished to me by the SUHC. I authorize payment of such benefits directly to SUHC. I understand that this assignment applies to outpatient, physician services furnished to me, cover previous visits, and will continue until revoked.

Medicare and Medicaid

I hereby assign to the Southern Ute Health Center such insurance benefits, if any, that I may have pertaining to payment for medical service and supplies furnished to me by the SUHC. I authorize payment of such benefits, if any, directly to SUHC. I understand that this assignment applies only to medical services and supplies furnished to me during the period designated. The release of clinical information required to substantiate appropriate insurance claims is authorized.

_____ _____

Patient Signature Date

_____ _____

Patient Representation Clerk Signature Date

HIPAA Notice of Privacy Practices

Southern Ute Tribal Health Department
69 Capote Dr.
Ignacio, CO 81137

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO), and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or in use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request the receive confidential communications from us by alternative means or at alternative location. You have the right to obtain paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____ Signature: _____
Date:_____

Privacy Act Signature Form

I understand that the information given by me and/or collected and stored in my health record is necessary for the Southern Ute Health Center staff to provide services for my health and wellbeing. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person without my consent.
I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records System at:

Southern Ute Health Center
69 Capote Drive
Ignacio, CO 81137
(970) 563-4581

Note: Psychotherapy notes will either be maintained at the Southern Ute Health Center or at a location the contracted provider deems fit.

_____ ____/____/____
Signature of Patient Date

_____ ____/____/____
Signature of Guardian for Minor or Court Ordered Guardian Date

_____ ____/____/____
Signature of Patient Registration Clerk Date

Consent of Parent of Legal Guardian or Other Person Who Has Primary Responsibility for the Care of a Child

_____ _____

Name of Child Date of Birth

I (We), _____,

have read the Southern Ute Health Center's Consent Form to arrange for or to provide the following health services for the above identified child:

1. Health care including medical examinations, routine laboratory studies, radiographic procedures, immunizations, and skin tests.
2. Dental care including dental examinations, preventive use of fluoride and necessary emergency dental care including radiographs.
3. Mental health services including evaluations and treatment as necessary.
4. Emergency healthcare for accidents or illness.
5. Transportation of the child to and/or from another health facility for these services.

☐ I (We) hereby give consent for all the above services.

☐ Exceptions or Special Instructions: _____

_____

I (We) designate the following individual(s) to bring the named child in for care:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Signature: _____

Address: _____ City/St/Zip:_____

Relationship: _____

Date: _____

Valid Until (max 1 year): _____ (if blank, valid for 1 year)

SOUTHERN UTE HEALTH CENTER

Authorization to Release Information TO the Southern Ute Health Center

Name:	**Date of Birth:**
Last four of Social Security #:	**Daytime Phone#**

INFORMATION IS TO BE DISCLOSED BY:	**INFORMATION IS TO BE PROVIDED TO:**
Name of Organization/Facility	**Name of Organization/Facility** Southern Ute Health Center
Address	**Address** 69 Capote Dr., PO Box 899
City, State, Zip	**City, State, Zip** Ignacio, CO 81137
Phone/Fax	**Phone/Fax** 970-563-4581/970-563-0206

PURPOSE OF THIS DISCLOSURE:

- ☐ **Further Medical Care**
- ☐ **Disability Determination**
- ☐ **Legal Investigation**
- ☐ **Payment of Claim/Benefits**
- ☐ **Personal Use**
- ☐ **Other (specify)**

INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD (check appropriate boxes):

- ☐ **Only information related to (specify)** _____
- ☐ **Only the period of events from** _____
- ☐ **Other (specify)** _____
- ☐ **Entire Record**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ **Alcohol/Drug Abuse Treatment/Reference**
- ☐ **Sexually Transmitted Disease**
- ☐ **Psychotherapy**
- ☐ **HIV/AIDS Related Treatment**
- ☐ **Mental Health (Other than Psychotherapy Notes)**

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or **receive** a **copy of the information to be used or disclosed:** I understand that I have the right to inspect or receive a copy of the health information I have authorized lo be used or disclosed

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to **refuse to sign this authorization:** I understand that I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment or eligibility for health care benefits based on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization.

Expiration Date: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

Date (Optional) _____

Patient or Legal Representative Signature/Relationship **Date of Signature**

SOUTHERN UTE HEALTH CENTER

Authorization to Release Information FROM the Southern Ute Health Center

Name:	**Date of Birth:**
Last four of Social Security #:	**Daytime Phone#**

INFORMATION IS TO BE DISCLOSED BY:	**INFORMATION IS TO BE PROVIDED TO:**
Name of Organization/Facility Southern Ute Health Center	**Name of Organization/Facility**
Address 69 Capote Dr., PO Box 899	**Address**
City, State, Zip Ignacio, CO 81137	**City, State, Zip**
Phone/Fax 970-563-4581/970-563-0206	**Phone/Fax**

PURPOSE OF THIS DISCLOSURE:

- ☐ **Further Medical Care**
- ☐ **Disability Determination**
- ☐ **Legal Investigation**
- ☐ **Payment of Claim/Benefits**
- ☐ **Personal Use**
- ☐ **Other (specify)**

INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD (check appropriate boxes):

- ☐ **Only information related to (specify)** _____
- ☐ **Only the period of events from** _____
- ☐ **Other (specify)** _____
- ☐ **Entire Record**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ **Alcohol/Drug Abuse Treatment/Reference**
- ☐ **Sexually Transmitted Disease**
- ☐ **Psychotherapy**
- ☐ **HIV/AIDS Related Treatment**
- ☐ **Mental Health (Other than Psychotherapy Notes)**

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or **receive** a **copy of the information to be used or disclosed:** I understand that I have the right to inspect or receive a copy of the health information I have authorized lo be used or disclosed

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

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Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization.

Expiration Date: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

Date (Optional) _____

Patient or Legal Representative Signature/Relationship **Date of Signature**

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Southern Ute Tribal Health Department to release my records and discuss any information requested to the following individuals.

1. _____ **Relation to Patient:** _____
2. _____ **Relation to Patient:** _____
3. _____ **Relation to Patient:** _____
4. _____ **Relation to Patient:** _____

Authorization Regarding Messages(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medicaltreatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____

Patient Name (PLEASE PRINT) Date

_____

Patient Signature

HEALTH QUESTIONNAIRE

Confidential Data

Name:	Date of Birth:	Date:
Reason for Visit and Symptoms:		

Other Medical Personnel Involved in Your Care

Name:	Phone number:	Reason:

Allergies/Intolerances

Allergen Name	Reaction	Start Date

Medication - List **all** prescription medications you currently take.

Medication	Start Date	Strength	How Often	Reason

Supplements - List **all** vitamins, hormones, alternative remedies or over the counter medications you use.

Medication	Start Date	Strength	How Often	Reason

Preventative Care - List date of last test or screening

Test	Date of last test or screening
Colonoscopy:	
Dental examination:	
DEXA (bone density):	
Eye Exam:	

Male Patients	Date of last test	Please check below symptoms if applicable
PSA laboratory test:		□ Diminished libido □ Difficulty obtaining or maintaining an erection
Rectal/prostate exam:		□ Urinary: decreased flow or delayed flow
Testicular exam:		□ Urethral discharge

<table>
<tr><td colspan="3">Name: Date of Birth: Date:</td></tr>
<tr><td colspan="2">Female Patients Date of Last Exam/Test</td><td>Menstrual History</td></tr>
<tr><td colspan="2">Breast exam:</td><td>Age of onset:</td></tr>
<tr><td colspan="2">Mammogram:</td><td>Date of last period:</td></tr>
<tr><td colspan="2">Pap smear:</td><td>Length of cycle:
□ regular □ irregular</td></tr>
<tr><td colspan="2">Rectal examination:</td><td>Days of flow:</td></tr>
<tr><td colspan="2">SEXUAL HISTORY</td><td>Flow Description:
□ Heavy □ Moderate □ Light
□ Pain □ Cramps □ Clots</td></tr>
<tr><td colspan="2">□ Pain during or after intercourse
□ Bleeding after intercourse
□ Diminished libido
□ Infertility</td><td>□ Menopause Symptoms (flushing, moodiness, changes in cycle, other)</td></tr>
<tr><td>No. of pregnancies</td><td></td><td rowspan="4">Age of menopausal onset</td></tr>
<tr><td>Live births</td><td></td></tr>
<tr><td>Miscarriages</td><td></td></tr>
<tr><td>Abortions</td><td></td></tr>
<tr><td colspan="3">Birth control method:</td></tr>
</table>

Name: Date of Birth: Date:

Health History

Are you being treated for, or have you had any of the following health conditions? Please check if applicable. Additional space is provided below for details or other health conditions not listed.

□ Allergies	□ Defibrillator	□ High blood pressure	□ Peripheral vascular disease
□ Alcohol Problems	□ Dementia	□ HIV/AIDS	□ Pleurisy
□ Anemia	□ Depression	□ Hyperthyroidism	□ Pneumonia
□ Aneurysm	□ Diabetes	□ Hypothyroidism	□ Prostate problems
□ Anxiety	□ Diarrhea	□ Irritable bowel	□ Seizure disorder
□ Arthritis	□ Diverticulosis or diverticulitis	□ Kidney disease	□ Sexually transmitted disease(s)
□ Asthma	□ Eating disorder	□ Kidney failure	□ Sleep apnea
□ Atrial fibrillation	□ Emphysema	□ Kidney stones	□ Stents
□ Bleeding problems	□ Fertility issues	□ Low back pain	□ Stroke
□ Blood clots	□ GERD	□ Lupus (SLE)	□ TIA
□ Blood transfusion	□ Glaucoma	□ Mental Illness/mood disorder	□ Tremors
□ Bronchitis	□ Goiter	□ MSRA infections	□ Tuberculosis
□ Cancer	□ Gout	□ Narcolepsy	□ Urinary
Type:	□ Headaches	□ Neuropathy	□ Valvular disease
□ CHF	□ Heart attack	□ Nervous System disease	□ Varicose veins
□ Crohn's disease	□ Heart disease	□ Obesity	□ Weight problems
□ Colitis	□ Heart Failure	□ Pacemaker	
□ Constipation	□ Hemorrhoids	□ Palpitations	
□ COPD	□ Hepatitis	□ Peptic ulcer(s)	

List additional information and other health conditions not listed above: _____

_____

_____

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HEALTH QUESTIONNAIRE
Confidential Data

Name:	Date of Birth:	Date:

Past Hospitalizations/Procedures/Surgeries

List surgical procedures, reasons for hospitalizations and the year.

Type	Approximate Date	Type	Approximate Date

Immunizations: List date of last injection and if record is attached.

Injection	Date	Record Attached?	Injection	Date	Record Attached?
Gardasil		□ Yes □ No	Pneumonia		□ Yes □ No
Hepatitis A		□ Yes □ No	Polio		□ Yes □ No
Hepatitis B		□ Yes □ No	Tetanus		□ Yes □ No
Influenza		□ Yes □ No	T-dap		□ Yes □ No
MMR		□ Yes □ No	Typhoid		□ Yes □ No
Meningitis		□ Yes □ No	Zostavax		□ Yes □ No

Social, Safety, Cultural, Communication History

Smoking Status □ Current daily smoker □ Current someday smoker □ Former smoker
□ Never smoker
If current or quit within 12 months, □ Cigarettes □Cigars □ Pipe □ Smokeless
If current or quit within 12 months, Smoking Cessation Counseling □ Yes □ No

Preferred language: Ethnicity □Hispanic/Latino □ Not Hispanic/Latino

Race: □ White □ African American □ American Indian/Alaskan □Asian □Hawaiian/Pacific Islander □ Other

Relationship status: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

Alcohol? □ Yes □ No □ Rarely Amount_____ drinks per day/week/month
Caffeine? □ Yes □ No Amount_____ cups per day/week/month

Do you/or have you had a problem with drug use □ Yes □ No If yes, list type

Do you exercise? □ Yes □ No If yes, list type frequency

Do you have children? □ Yes □ No If yes, how many? ___
Seatbelt usage? □ Yes □ No Percent of time worn:

Have you been hit or threatened in the past year? □ Yes □ No

Are there cultural or religious beliefs that need to be considered in your care? □ Yes □ No
If yes, explain:

Potential barrier to learning: □ none □ inability to understand English
□ Language (if other than English) □ blind □ poor vision □ deaf □ decreased hearing
□ unable to talk □ unable to read □ memory loss

Learns best by: □ reading □ verbal instruction □ practicing □ talking □ watching □ other

Do you have a:
Durable Power of Attorney? □Yes □ No If yes, list person(s):_____
Healthcare representative? □Yes □ No If yes, list person(s): _____
Living Will? □Yes □ No If yes, list person(s): _____
DNR Do Not Resuscitate? □ Yes □ No
Would you like information on any of the above? □ Yes □ No

HEALTH QUESTIONNAIRE
Confidential Data

Name:	Date of Birth:	Date:

Family History Mark the appropriate box	**Alive and well**	**Deceased**	**Age at death**	**Cause of death**	**High blood pressure**	**Heart disease**	**High cholesterol**	**Diabetes**	**Cancer**	**Asthma**	**COPD**	**Tuberculosis**	**Arthritis**	**Kidney disease**	**Glaucoma**	**Stroke**	**Migraine**	**Mental illness**	**Alcoholism**	**Anemia**	**Gout**	**Seizures**
Father																						
Paternal Grandfather																						
Paternal Grandmother																						
Mother																						
Paternal Grandfather																						
Paternal Grandmother																						
Sibling 1																						
Sibling 2																						
Sibling 3																						
Sibling 4																						
Spouse																						

Additional Comments or Information:

_____

_____

_____

Person completing form Signature Date