Asher Community Health Center

Patient Registration Form

Patient Information

Last Name:	First Name:	Middle Name:
Social Security Number:	Date of Birth:	Gender: Male / Female
Street Address: P.O. Box:	City:	State: / Zip:
Telephone (Home):	Marital Status: Single / Married / Partnered / Separated / Divorced / Widowed	
Telephone (Work):	Name of Spouse/Partner:	
Mobile:	Driver's License (Issuing State/Number):	
Email :	Contact By: Phone / Mail / Do Not Contact	
Primary Language:	Interpreter Needed: Yes / No	What Language:
Race: Asian / Alaskan Native / American Indian / Black / Native Hawaiian / Pacific Islander / White / Not Collected / Unknown		
Ethnic Group: Hispanic / Non-Hispanic / Not Collected / Unknown	Are you a Veteran?	
Student Status: Full-time / Part-time / NA	Employment Status: Full-time / Part-time / Self / Retired / Active Military / None	
Employer Name:	Occupation:	
Address:	City:	State: / Zip:
Employer Telephone:	Date of Employment:	
Are You an Agricultural Worker? Yes / No	If Yes: Seasonal / Migrant	
Family Size:	Total Annual Household Income:	
Do You Consider Yourself Homeless (circle one): Living in a Shelter or Gospel Mission / Street, Camp, or Bridge / At Risk for Homeless / Transitional		
Living with others (more than one family per home) / Current not Homeless, was in the Last 12 Months		
Primary Care Provider:		
Circle all that apply: Air Link Membership Life Flight Membership None		

Responsible Party Information

☐ Same as Above	Patient's Relationship to Responsible Party: Self / Spouse / Partner / Child / Guardian	
Last Name:	First Name:	Middle Name:
Social Security Number:	Date of Birth:	Gender: Male / Female
Address:	City:	State: / Zip:
Telephone (Home):	Marital Status: Single / Married / Partnered / Separated / Divorced / Widowed	
Telephone (Work):	Name of Spouse/Partner:	
Driver's License (Issuing State/Number):	Contact By: Phone / Mail / Do Not Contact	
Primary Language:	Interpreter Needed: Yes / No	What Language:
	Employment Status: Full-time / Part-time / Self / Retired / Active Military / None	
Employer Name:	Occupation:	
Address:	City:	State: / Zip:
Employer Telephone:	Date of Employment:	
Family Size:	Total Annual Household Income:	

Emergency Contact Information

1st Contact Name:		Spouse / Partner / Parent / Child / Sibling / Friend / Attorney		
Telephone (Home/Work):	Address:	City:	State:	Zip
2nd Contact Name:		Spouse / Partner / Parent / Child / Sibling / Friend / Attorney		
Telephone (Home/Work):	Address:	City:	State:	Zip

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Consent to Treat

Authorization/Release: I hereby authorize Asher Community Health Center to provide medical services, including surgery if necessary, either regular or emergency, as may be determined to be in the best interest of myself or patient above, for whom I am legally responsible, even if the patient is a minor.

I also agree to assign benefits to Asher Community Health Center from any policy used to reimburse charges incurred during my, or the patient's, visit with Asher Community Health Center. I understand that revoking my consent will eliminate benefit payment and that I am financially responsible for all charges whether or not covered by insurance. This authorization shall remain valid until written notice is given by me.

Patient Name:______________________________

Signature: _________________________________ Date: __________

(parent /legal guardian if under 15)

MRN#______________

Asher Community Health Center

Asher Clinic Services

Receipt for Notice of Privacy Practices

Please review this carefully.

The Notice of Privacy Practices you have received explains how Asher Community Health Center (ACHC) may use or disclose Protected Health Information (PHI) about you. The Notice of Privacy Practices may not describe all circumstances, however, under which ACHC may be authorized to release your PHI.

I attest that I have received a copy of ACHC's Notice of Privacy Practices and have had a chance to ask questions about how my information may be used or disclosed.

______________________ ______________________ ______________________

Patient Name (please print) **Patient signature** or parent/legal guardian if under 15 **Date**

DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

Please list names of persons below to whom you give permission for Asher Community Health Center to release your personal health information: (spouse, relative, close friend etc…)

1.______________________ 2.______________________ 3.______________________

______________________ ______________

Patient signature or parent/legal guardian if under 15 **Date**

At times, ACHC has a need to reach a patient for reasons related to their care. This might be to request a follow-up appointment or to schedule an appointment to discuss lab results. **If I am not available when called by an ACHC employee, I approve to have a message left for me with the person who answers the phone or you may leave a message via voice mail or answering machine.**

______________________ ______________

Patient signature or parent/legal guardian if under 15 **Date**

*****for office use only*****

Date Disclosed	Name/Address of person/entity receiving PHI	PHI Information Disclosed	Purpose of Disclosure	Disclosed by

MRN #__________

Please print using blue or black ink

Full name: ______________________________

MEDICAL HISTORY:

HAVE YOU EVER HAD AN ALLERGY OR NEGATIVE REACTION TO A MEDICATION

MEDICATION:	REACTION:

Do YOU have, or have you ever had any of the following? Mark Yes or No

	YES	NO		YES	NO		YES	NO
Allergies			Anemia			Anxiety		
Arthritis			Asthma			Blood Transfusion		
Cancer			Cataracts			CHF (heart failure)		
Clotting (bleeding)			COPD			Depression		
Diabetes			Emphysema			Heart Burn		
Glaucoma			Heart Murmur			HIV/AIDS		
High Blood Pressure			Kidney Disease			Meningitis		
MI (Heart Attack)			Nerve/Muscle problem			Osteoporosis		
Seizures			Sickle Cell Anemia			Stroke		
Substance Abuse			Thyroid Disease			TB (Tuberculosis)		
Ulcers			Other			Other		

SURGICAL HISTORY:

Have YOU ever had any of the surgeries listed below? If you have had a procedure not listed, please note under other.

	YES	NO		YES	NO		YES	NO
Appendectomy			C-Section			Prostate Surgery		
Brain Surgery			Eye Surgery			Small Intestine		
Breast Surgery			Fracture Surgery			Spine Surgery		
CABG/heart			Hernia repair			Tubal Ligation		
Gallbladder			Hysterectomy			Valve Replacement		
Colon Surgery			Joint replacement			Vasectomy		
Cosmetic Surgery			OTHER			OTHER		

Immunizations	Date Received	Place Where Immunization Received
Tetanus		
Flu		
Shingles		
Pneumonia		
HPV		
Other		

Have you had any special tests?	YES	NO	Date and Place Performed
EKG			
Colonoscopy			
Echocardiogram			
Other			

FAMILY HISTORY

	If Living		If Deceased		Alcohol/drug abuse	Arthritis	asthma	cancer	Heart problems	Depression	High Cholesterol	High Blood	Kidney Disease	Mental Illness	Stroke	Vision Problems
	Age	Health	Age at death	Cause of Death												
Mother:																
Father:																
Brother or Sister:																
Children:																

SOCIAL HISTORY:

Do you currently or have you in the past drank alcohol?	never	current	past
Type	**Amount Per Day**		
Glasses of wine			
Cans of beer			
Shots of Liquor			
Drinks containing .5 oz of alcohol			
Ready to quit?			

Tobacco

Do you currently or have you in the past used tobacco?	never	current	past
Type	Amount Per Day	# of years	Date quit
Cigarettes			
Cigars			
Pipe			
Chew			
Ready to quit?	Yes or No		

Current Medications

Drug Use

Do you currently or have you ever used any of the following?	never	current	past
Type	**# of Times, Each Week**		**Date Quit**
Marijuana			
Ecstasy			
Meth			
Heroin			
Cocaine Crack			
Pain Pills			

Marital Status	Single	Married	Divorced	Widowed

Occupation		How Long?

Sexual Health

Sexual Activity	Yes	No	Not currently
LMP	**Date:**		
Birth Control	**Method:**		

Sexual Orientation	Straight not Lesbian or Gay	Lesbian	Gay	Bisexual	Something Else	Don't Know	Choose not to Disclose
Gender Identity	Male	Female	Trans Male to Female	Trans Female to Male	Other	Choose not to Disclose	