# Community Medical Clinic

## Community Medical Clinic: Community Health Center (*Adult Intake Form*)

**In order to help the check in process, please fill in ALL information.**

## PART A

### I. Patient Information

_____, _____, _____

*Last Name* *First Name* *Middle Name*

**What name would you like to go by?** _____

**Address:**_____ **Zip Code**: _____

**Home Phone:** (___)_____ **Cellular:** (___)_____**Work**: (____)_____

**Email Address:**_____ **Preferred Communication:** ☐ Phone ☐ Text ☐ Email

**Preferred Phone Contact:** ☐ Home ☐ Cell ☐ Work

**Circle Gender at Birth: M / F** **SSN:** _____ - _____ -_____ **Date of Birth:** _____

**Gender Identification (please choose one)**: ☐ Male ☐ Female ☐ Transgender- male-to-female

**Sexual Orientation (please choose one):** ☐ Lesbian or Gay ☐ Straight (not Lesbian or Gay) ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose Not To Disclose

**Marital Status:** ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widow / Widowed ☐ Unknown

**Education:** (choose the highest education level completed)

☐ None ☐ 1-6 grade ☐ 7-8 grades ☐ some high school ☐ GED ☐ High school diploma ☐ some college ☐ Bachelors' degree ☐ Masters' degree or higher

**Race:** ☐ Native American/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Other

**Ethnicity:** ☐ Hispanic / Latino ☐ Non-Hispanic / Non-Latino

Other:_____

**Preferred Language:** ☐ English ☐ Spanish ☐ Other_____

☐ Interpreter Needed?

**Living Situation:** ☐ Homeless ☐ Not Homeless ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown

**Agricultural Worker:** ☐ Migrant ☐ Seasonal ☐ Not an Agricultural Worker

**Are you a U.S. Veteran?** ☐ Yes ☐ No

**Who is / was your last Primary Care Provider?** _____

**Reason for Transfer of Care (if transferring):**_____

**How did you hear about us?**_____

## IN CASE OF EMERGENCY

**Please contact (name):**_____ **Phone(s):**_____

**Address:**_____**Relation:**_____

**Preferred Pharmacy:**_____**Phone:**_____

## INSURANCE INFORMATION

**Primary Insurance:** _____ **ID#**_____ **Group#**_____

**Subscriber's Name:**_____ **DOB:**_____ **Phone#**_____

**Secondary Insurance:**_____ **ID#**_____ **Group#**_____

**Subscriber's Name:**_____ **DOB:**_____ **Phone#**_____

**Subscriber Address (if different than the patient):** _____

_____

## II. RESPONSIBLE PARTY INFORMATION

**Employment:** ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full-Time Student ☐ Retired ☐ Active Military ☐ Unknown

**Responsible Party Name:** _____**Employer Name:**_____
**Employer Address:** _____**Employer Phone:**_____

**Are you seeking treatment that is related to a Workers Compensation or Auto Accident injury?** ☐ Yes ☐ No

**Please List anyone here that you wish to have access to your health care information in the invent you are unavailable. (i.e. - Pick up a prescription, receive results, make and confirm appointments)**
**List exclusion to the above permission's**

_____

## V. HOUSEHOLD INCOME INFORMATION

***Note:*** ***As a Federally Qualified Health Center (FQHC), we provide Sliding Fee Scales which may help you with your health care expenses. To help us determine if you may qualify, please answer below.*** **This information is only used to obtain the grants we use to help those who do not have insurance and will not affect you in any adverse way.**

**What is your annual household income?_____ How many people are in your household?_____**

☐ No Income ☐ Less than 24,999 ☐ 25, 000 to 39,999 ☐ 40,000 to 59,999 ☐ 60,000 to 99,999

☐ 100,000 or more

***If you are interested to know more about our Sliding Fee Scale Program, please fill out the enclosed Sliding Fee Scale discount program section below.***

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## Community Medical Clinic

# A sliding scale **discount program is available for our uninsured and under-insured patients who may have difficulty paying.**

□ Yes, I am interested in information regarding the sliding scale program.

□ No, I am not interested at this time in the sliding scale program and I do not wish to disclose my income.

Signature: _____

Date: _____

**Once the paper is signed, please return it to the receptionist.**

Pennyroyal Healthcare Services, Inc DBA Community Medical Clinic

# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

**I. My Authorization**

I authorize the following using or disclosing party:

_____

**To use or disclose the following health information:** (check one)

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

☐ - Other: _____

**The above party may disclose this health information to the following recipient:**

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

**The purpose of this authorization is:** (check all that apply)

☐ - At my request

☐ - Other: _____

☐ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

**This authorization ends:** (check one)

☐ - On (date)_____

☐ - When the following event occurs: _____

**II. My Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

**Signature of Patient**: _____

Date: _____

**If the patient is a minor or unable to sign, please complete the following:**

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

**Signature of Authorized Representative**: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

**III. Additional Consent for Certain Conditions**

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

**Signature of Patient or Authorized Representative**: _____

Date: _____ Time: _____

**IV. Additional Consent for HIV/AIDS**

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

**Signature of Patient or Authorized Representative**: _____

Date: _____ Time: _____

## VI. Required Information and Acknowledgements

### Release of Medical Records

In the event that my physician / provider recommends (and I agree to) referral to a specialist, an outside Health Care Center, or other outside medical provider, I hereby authorize Community Medical Clinic to release my medical records as required to the indicated specialty physician, provider and/or the referral health center for the purpose of continuity of care.

I understand that this release does not apply to my behavioral health records, HIV/AIDS status, nor substance (drug, alcohol, etc.) abuse information, if it exists. If there is need for the release of behavioral health records, substance abuse history, or HIV/AIDS status, I will be notified. I will need to complete another Release of Information form specifically granting my consent for such release, if I agree to the records transfer.

I also understand that if I am being referred to a specialist physician or provider, or to a specialty health center, Community Medical Clinic will make the referral to the qualified entity of the patient's choice. If the patient's preferred entity refuses the referral, can't see the patient in a timely manner, or is unavailable, the Community Medical Clinic referral team will seek 'likes specialists' (i.e. physicians, providers, or specialty health centers) to provide care for the patient.

I understand that this release of my medical information is required to facilitate a referral (which is made by my Community Medical Clinic provider and accepted by me) stays in force unless I revoke it in writing to Community Medical Clinic.

**Patient Signature**:_____ **Date**:_____

**Patient's Legal Representative's Signature (if needed)**_____ **Date:**_____

### CONSENT for TREATMENT

In seeking medical care from Community Medical Clinic, I do hereby voluntarily consent to such examination and treatment as is deemed necessary by Community Medical Clinic. I understand the practice of medicine is not an exact science, and that diagnosis and treatment involve risks of injury or even death. I acknowledge that Community Medical Clinic providers have made no guarantees to me as a result of examination or treatment.

**Patient / Representative Signature:**_____ **Date:**_____

**Do you have an Advance Directive?** ☐ **yes** ☐ **no**

**If no, would you like some information about Advance Directives?** ☐ **yes** ☐ **no**

## Patient Acknowledgement:

**Cancellation of Appointments.** I agree to schedule appointments for my treatment. I agree that I will call and cancel my appointment at least 24 hours prior to the appointment time, if cancellation is necessary. I understand that if I have three missed or cancelled appointments, I may be discharged from the Health Center practice.

**No Call / No Show.** I understand that missing 3 appointments within 12 months as a no call/no show **may** cause me to be discharged from the practice.

I understand that if I have any problems getting to my appointment, I can let Community Medical Clinic know in advance and they may be able to **help me with transportation**.

**Notice of Privacy Practices.** I have received a copy of the Notice of Privacy Practices.

**Responsibility for Payment.** For and in consideration of services rendered, or to be rendered, to the named patient, I or we, or either of us do hereby promise to pay Community Medical Clinic the full amount of all charges incurred. I/we understand that Community Medical Clinic will file commercial insurance as a courtesy. Community Medical Clinic will allow 30 days for the insurance to resolve the outstanding charges.

**Patient / Representative Signature:_____ Date:_____**

**Co-Signature (if needed)_____ Date:_____**

## END PART A

***Please continue to the next section, PART B.***

Part B

# Medical History Form

| Name: | Male ( ) Female ( ) | DOB: |
|---|---|---|
| Previous Doctor: | Date of last physical Exam: | |

| Any Specialists You See: | Reason you see this Specialist |
|---|---|
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| Medical Conditions you have been diagnosed with in the past: |
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| **Allergies to Medications or Substances:** |
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| |

| Surgeries | Date/Hospital |
|---|---|
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| | |
| **Colonoscopy? Yes ( ) No ( )** | **Date of Most recent Colonoscopy:** |
| | |

| Other Hospitalizations | Date/Hospital |
|---|---|
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**List All Prescribed and Over the Counter Medications you take including vitamins and inhalers**

| Name of Drug | Strength | Frequency taken |
|---|---|---|
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| Personal Habits/Social History | | |
|---|---|---|
| Do you drink alcohol? | YES_____ | NO_____ |
| -If yes, how may drinks per week? | | |
| - Are you concerned about the amount you drink? | Yes_____ | No_____ |
| - Have you considered stopping drinking? | YES_____ | NO_____ |
| Do you use tobacco? | Yes_____ | No_____ |

| | | |
|---|---|---|
| Cigarettes ( ) #per day_____ | Smokeless Tobacco ( ) | Pipe ( ) |
| Number of years smoked_____ | Ready to Quit ( ) | |
| Former Smoker Yes ( ) No ( ) | Year Quit _____ | |

| | |
|---|---|
| Do you currently use any recreational/street drugs? | Yes ( ) No ( ) |
| Have you ever injected street drugs with a needle? | Yes ( ) No ( ) |
| | |
| Are you sexually active? | Yes ( ) No ( ) |
| Any concerns for STD or diseases such as HIV/AIDs? | Yes ( ) No ( ) |
| | |
| Safety Concerns: | Yes ( ) No ( ) |
| Do you live alone? | Yes ( ) No ( ) |
| Do you have frequent Falls? | Yes ( ) No ( ) |
| Do you have vision or hearing loss? | Yes ( ) No ( ) |
| Do yo uhave an Advance Directive or Living Will? | Yes ( ) No ( ) |
| Has anyone hit your or hurt you physically in the past ? | Yes ( ) No ( ) |
| Has anyone verbally abused you? | Yes ( ) No ( ) |
| Do you feel safe? | Yes ( ) No ( ) |

**Immunizations:**

| | |
|---|---|
| Influenza vaccine Y ( ) N ( ) Date: | Pneumonia Vaccine Y ( ) N ( ) Date: |
| Tetanus/TDAP Y ( ) N ( ) Date: | Shingles Vaccine Y ( ) N ( ) Date: |

**Self and Family Medical History**

List any Significant health problems such as diabetes, heart disease, stroke, COPD, Mental illness, Hypertension, cancer that your family members have had

| | |
|---|---|
| Father: | Alive ( ) Deceased ( ) |
| Mother: | Alive ( ) Deceased ( ) |
| Children: | Alive ( ) Deceased ( ) |
| Siblings: | Alive ( ) Deceased ( ) |
| Maternal Grandmother: | Alive ( ) Deceased ( ) |
| Maternal Grandfather: | Alive ( ) Deceased ( ) |
| Paternal Grandmother: | Alive ( ) Deceased ( ) |
| Paternal Grandfather: | Alive ( ) Deceased ( ) |

**Women's Health- only applies to female patients**

| |
|---|
| Are you pregnant or breastfeeding? Yes ( ) No ( ) |
| Number of Pregnancies_____ Number of live births_____ |
| Date of last menstrual period:_____ |
| Date of last pap?_____ |
| Date of last mammogram_____ |

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

TOTAL: _____

**10.** If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____



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