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.

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.

Community Medical Clinic
Medical Record Release (From)

1102 S Virginia St
Hopkinsville, KY 42440
Phone: 270-632-6741
Fax: 270-632-6742

Requesting From: _____
_____
_____
Fax: _____

PLEASE MAIL IF OVER 25 PAGES

RE:

_____ Date(s) of Requested information: _____

DOB: _____

___Health & Physical ___Medication History ___Lab Report

___Height/Weight/Vitals ___Length of Treatment ___Treatment Notes

___Physical Health Evaluation ___Discharge Summary ___Diagnosis

___Other_____

I understand the purpose for releasing this information if for:

_____

_____

I understand I may refuse to sign this authorization and my refusal will not prevent my receiving services.

I understand I may revoke this authorization, at any time, if requested in writing to Community Medical Clinic, except if Community Medical Clinic has already undertaken an action in reliance upon it, and that in any event this consent expires automatically as follows:

_____
(Specify date, event or condition)

I understand pursuant to K.R.S. 304 17A-555-My Protected Health Information, released under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to be re-disclosure.

I have read and understand this authorization.

_____ _____
(Individual Signing Authorization) (Date Signed)

If not signed by the client, specify basis for authority to sign: ___Parent ___Spouse ___Personal Representative ___Other:

_____ (Descript Authority to Sign)

_____ _____
(Staff Signature) (Date Signed)

Community Medical Clinic
HIPPA Release of Information (To)

I, _____ authorize the following from my Protected Health Information:

___Health & Physical ___Medication History ___Lab Report

___Height/Weight/Vitals ___Length of Treatment ___Treatment Notes

___Physical Health Evaluation ___Discharge Summary ___Diagnosis

___Other_____

This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

I understand I may revoke this authorization, at any time, if requested in writing to Community Medical Clinic, except if Community Medical Clinic has already undertaken an action in reliance upon it, and that in any event this consent expires automatically.

I understand pursuant to K.R.S. 304 17A-555-My Protected Health Information, released under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to be re-disclosure.

I have read and understand this authorization.

_____ _____

(Individual Signing Authorization) (Date Signed)

If not signed by the client, specify basis for authority to sign: ___Parent ___Spouse ___Personal Representative
___Other: _____(Descript Authority to Sign)

_____ _____

(Staff Signature) (Date Signed)

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

Medical Conditions you have been diagnosed with in the past:
Allergies to Medications or Substances:

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

Other Hospitalizations	Date/Hospital

List All Prescribed and Over the Counter Medications you take including vitamins and inhalers

Name of Drug	Strength	Frequency taken

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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