# 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

_____

## 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.**

**Community Medical Clinic**
**Medical Record Release (From)**

310 Hawthorne St.
Princeton, KY 42445
Phone: 270-365-0227
Fax: 270-365-2559

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

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

| Other Hospitalizations | Date/Hospital |
|---|---|
| | |
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| | |
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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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