PATIENT REGISTRATION FORM

GENERAL INFORMATION

Patient Name _____**SSN:**_____**DOB:**_____
First name Last Name Initial

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip Code** _____

Sex: ___**M** ____**F** **Age** ___ **Marital Status** _____ **Ethnicity: (Hispanic/Latino):** ____**Yes** ____**No**

Race: (circle one) Asian American Indian Black Pacific Islander White
Multi Other: (specify) _____

Primary Language: _____ **U.S. Veteran?** _____**Yes** _____ **No**

Are you Homeless? ____ **Yes** ____ **No** **Do you live in public housing?** _____**Yes** _____ **No**

Do you need help with translation? _____**Yes** _____**No** **Do you have any physical disabilities:** _____ **Yes** ____ **No**
If yes, do you need any special help? _____

Responsible Party _____ **Employed By** _____

Business Name _____ **Business Phone** _____

Monthly Income _____ **Number of Dependents** _____

SOURCE OF INCOME: EMPLOYMENT $_____**AFDC: $**_____ **SSI: $**_____ **CHILD SUPPORT: $** _____
SOC. SEC: $ _____ **SELF EMPLOYED: $** _____ **UNEMPLOYMENT: $** _____**OTHER (specify)**_____

YOUR LEVEL OF EDUCATION: _____**High School not Complete**_____**High School Diploma**_____**College Education**

Emergency Contact Name: _____ **Phone Number:** _____

Other person/s authorized to bring your child to the doctor: _____ **Relationship:**_____

INSURANCE INFORMATION (Please present ID card at check-in)

MEDICARE# _____ **MEDICAID #** _____

Private Insurance Company: _____**HMO:** _____

Contract#: _____ **Group#:** _____ **Subscriber#:** _____

Name of Insured _____ **Employed by** _____
First Name Last Name

Relation to Patient _____ **Social Security Number:** _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that all the information provided is accurate. I understand that I am financially responsible for any and all charges not covered by insurance of the program for which I qualify. I hereby authorize Bond Community Health Center to release any information to collect payment of benefits. I authorize the use of this signature on all payment and insurance submissions.

_____ _____
Patient/Legal Guardian Signature **Date**

_____ _____
Witness Signature **Date**

GENERAL CONSENT FOR TREATMENT

I, THE UNDERSIGNED, GRANT PERMISSION FOR MYSELF OR MINOR CHILD(REN) TO UNDERGO ALL NECESSARY TESTS, EXAMINATIONS, TREATMENTS, AND OTHER PROCEDURES REQUIRED IN THE COURSE OF STUDY, DIAGNOSIS, AND TREATMENT OF ILLNESS BY MEDICAL PRACTITIONERS AND OTHER STAFF MEMBERS OF BOND COMMUNITY HEALTH CENTER, INC.

I AM AWARE THAT THE PRACTICE OF MEDICINE AND MINOR SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS A RESULT OF TREATMENTS OR EXAMINATION BY BOND COMMUNITY HEALTH CENTER, INC.

I CONSENT TO THE RELEASE OF MEDICAL AND DEMOGRAPHIC INFORMATION TO AUTHORIZED INSTITUTIONS OR GOVERNMENTAL AGENCIES AS IS REQUIRED BY BOND COMMUNITY HEALTH CENTER, INC.

I HEREBY AUTHORIZE PAYMENT TO BOND COMMUNITY HEALTH CENTER, INC OF BENEFITS OTHERWISE PAYABLE TO ME; OF MEDICAID; MEDICARE AND THIRD PARTY INSURANCE BENEFITS, BUT NOT TO EXCEED THE HEALTH CENTER'S REGULAR CHARGES FOR THIS PERIOD OF TREATMENT.

_____ _____

(PATIENT OR LEGAL GUARDIAN) **DATE**

_____ _____

(INTAKE SPECIALIST – WITNESS) **DATE**

CLIENT PARTICIPATION AGREEMENT

This is to certify that _____ Social Security Number
Patient Name
_____and the following members of his/her family may

receive services from Bond Community Health Center, Inc.

FAMILY MEMBERS	SOCIAL SECURITY NUMBER	DATE OF BIRTH

The following services are offered: Physical Exams, Screenings, Prescription Medicine, Prenatal Care, X-Rays, Immunizations, Pediatric Care, STD/STI Screening and Treatment, HIV Testing and Treatment, Nutritional Counseling, Health Education, Behavioral Health, Well and Sick Care, Medical Follow-up and Dental Services.

These services have been explained to me. I understand that although I or other members of my family may be referred for specialty care, hospitalization or high level care, there is no obligation for the provider to pay for these services. I understand that I may be responsible for my family and me. I will notify Bond Community Health Center, Inc. when one of my family members cannot keep an appointment.

I certify that all information I have given regarding income and family size are true and correct to the best of my knowledge. I understand that any slide scale discount that I qualify for will be in effect for 12 months unless there are significant changes in income or household size. After that time, I will be required to re-apply. I also understand that any falsification of documentation may result in my being charged full cost of receiving services.

_____ Yes, I would like to apply for a sliding fee discount

_____ No, I do not wish to apply for a sliding fee discount

_____ _____
(Patient or Legal Guardian) **Date**

_____ _____
(Intake Signature as Witness) **Date**

Bond Community Health Center – Patient Health History

Patient Name: _____ **Today's Date:** _____

Age: _____ **Birthday:** _____ **Date of Last Physical Examination:** _____

What is your reason for this visit? _____

REVIEW OF SYMPTOMS: **Check symptoms you currently have or have had in the past year.**

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

GASTROINTESTINAL
- □ Appetite Poor
- □ Bloating
- □ Bowel Changes
- □ Constipation
- □ Diarrhea
- □ Excessive Hunger
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting

EYE, EAR, NOSE, THROAT
- □ Bleeding Gums
- □ Blurred Vision
- □ Difficulty Swallowing
- □ Double Vision
- □ Ear Ache
- □ Ear Discharge
- □ Hay Fever
- □ Hoarseness
- □ Loss of Hearing
- □ Nosebleeds
- □ Persistent Cough
- □ Ringing in Ears
- □ Sinus Problems
- □ Vision – Flashes
- □ Vision – Halos

MUSCLE/JOINT/BONE

Pain, weakness, and/or numbness in:
- □ Arms □ Hips
- □ Back □ Legs
- □ Feet □ Neck
- □ Hands □ Shoulder

CARDIOVASCULAR

Pain, weakness, and/or numbness in:
- □ Chest Pain
- □ High Blood Pressure
- □ Irregular Heart Beat
- □ Low Blood Pressure
- □ Poor Circulation
- □ Rapid Heart Beat
- □ Swelling of Ankles
- □ Varicose

GENITO-URINARY
- □ Blood in Urine
- □ Frequent Urination
- □ Lack of Bladder Control
- □ Painful Urination

SKIN
- □ Bruise Easily
- □ Hives
- □ Itching
- □ Change in Moles
- □ Rash
- □ Scars
- □ Sore That Won't Heal

CONDITIONS: **Check conditions you currently have or have had in the past year.**
- □ AIDS/HIV
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Arthritis
- □ Asthma
- □ Bleeding Disorder r
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ Kidney Disease
- □ Liver Disease
- □ Headaches
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problems
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease/STD/STI

WOMEN ONLY

Are you pregnant □ Yes □ No

Age at Onset of Period: _____

Menstrual Flow: □ Regular □ Irregular □ Cramps

_____ Days of Flow _____ Length of Cycle

1st Day of Last Period _____

□ Pain/Bleeding during or after sex

Number of:

____ Pregnancies _____ Abortions

____ Miscarriages _____ Live Births

Birth Control Method: _____

Date of last PAP test: _____

□ Normal □ Abnormal

MEN ONLY
- □ Breast Lump
- □ Erectile Difficulties
- □ Lump in Testicles
- □ Penis Discharge
- □ Sore on Penis

MEDICATIONS: List Medications you are currently taking

MEDICATIONS	MEDICATIONS	ALLERGIES

FAMILY HISTORY:

Disease	Relationship to you
Anemia	
Arthritis	
Asthma	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS/SURGERY:

Year	Reason for Hospitalization/Surgery

Violence/Abuse in the Family? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No

If yes, please give approximate dates: _____

Tuberculosis: PPD date _____ Results _____ mm _____ CXR(date) _____ Results _____

HEALTH HABITS:

Tobacco Use: □ Yes □ No Amount _____ Stopped(date) _____

Alcohol Use: □ Yes □ No Amount _____

Street Drugs: □ Yes □ No Type _____ Amount _____

Exercise: □ Yes □ No Describe _____

Seat Belt Use: _____ Always _____ Sometimes _____ Never

SEXUAL HISTORY:

More than 1 partner in past 5 years?	□Yes	□ No	More than 1 partner in past year?	□ Yes	□ No
Sex with male	□Yes	□ No	Victim of Sexual Assault	□ Yes	□ No
Sex with female	□Yes	□ No	Sex w/injection drug user?	□Yes	□ No
Sex while using non-injection drugs	□Yes	□ No	Sex w/man who had sex w/man?	□Yes	□ No
Sex for drugs/money?	□Yes	□ No	Sex with person with HIV/AIDS	□Yes	□ No

CONTRACEPTIVE HISTORY

Method last used/using now _____
Other method used _____
Problem with method? _____

Staff Signature/Title _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, have received the Notices of
Print Name

Privacy Practices from Bond Community Health Center, Inc.

_____ _____
Patient/Legal Guardian Signature Date

In lieu of patient signature, I, _____, a staff member

of Bond Community Health Center, Inc., state that _____

has received our current Notice of Privacy Practices.

_____ _____
Intake Specialist Date