San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered:

Patient Registration Form

PLEASE PRINT CLEARLY

Patient's Legal Name: _____ AKA (Also Known As): _____

SSN: _____ **Birthdate**: _____ **Primary Care Provider:** _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female Male-to-Female ☐ Other ☐ Choose not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Ethnicity (select one): ☐ Hispanic or Latin Origin ☐ NOT Hispanic or Latin Origin

Race (Select one):

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

If American Indian/Alaskan Native:
Tribe: _____ Enrollment #: _____ Indian Blood Quantum: _____

If you are not American Indian/Alaskan Native, are you a member of an Indian household? ☐ Yes ☐ No

Primary Language: _____ Preferred Language: _____ Interpreter Required: ☐ Yes ☐ No

English Proficiency: ☐ Not at all ☐ Not Well ☐ Well ☐ Very Well

Home Address: _____ **Apt #**_____

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

Mailing Address (if different from home): _____

Home Phone#: _____ **Work Phone #:** _____ Ext: _____ **Cell Phone #:** _____

Can we leave a message on the above phone numbers? ☐ Yes ☐ No **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Mail

Internet Access: ☐ Yes ☐ No **If YES**, where? ☐ Home ☐ Work **Email Address:** _____

Would you like to sign up for the Personal Health Record (PHR) where you can view your health information? ☐ Yes ☐ No

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Emergency Contact

Primary Contact Name: _____ Relationship: _____

Home/Cell Phone #: _____ Work Phone #: _____

Secondary Contact Name: _____ Relationship: _____

Home/Cell Phone #: _____ Work Phone #: _____

Please complete reverse side

San Diego American Indian Health Center

Patient Registration Form

Person Responsible for Patient's Financial Obligation, If Self, Please Indicate:

Name: _____ Relationship: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Home Phone#: _____ Daytime/Cell Phone#: _____

Work Phone#: _____ Ext#: _____

Home Address (If Different from Patient's address):

_____ City _____ State _____ Zip_____

Employer Name: _____City/State/Zip Code: _____

As a Federally Qualified Health Center, SDAIHC is required to report the following information for the population we serve:

Number of People in Household (Immediate family ***only***) _____ **Household Income** (Monthly) _____

Migrant Worker (or dependent of)**:** ☐ Yes ☐ No **Homeless:** ☐ Yes ☐ No

U.S. Veteran: ☐ Yes ☐ No **If yes, Branch:** _____ **Vietnam Vet:** ☐ Yes ☐ No

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

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To the best of my knowledge, all of the information above is true and correct.

I hereby authorize Medical/Dental/Psychological treatment for the above patient.

Patient/Guardian Signature: _____ **Date:** _____

If Guardian, Print Name: _____

Relationship to Patient: _____

San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered: _____

Insurance Information

PLEASE PRINT CLEARLY

Patient's Legal Name: _____ DOB: _____/_____/_____

Primary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective/Issue Date: _____

Secondary Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective/Issue Date: _____

Dental Insurance

Insurance Co: _____

Insurance Phone#: _____

Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Policy #: _____

Group #: _____

Effective Date: _____

PLEASE COMPLETE REVERSE SIDE

San Diego American Indian Health Center

HRN _____

Received By: _____

Date Entered: _____

Assignment of Benefits

By signing below:

- I, the undersigned, hereby authorize assignments of and direct billing to Medi-Cal, Medicare and/or any other insurance benefits to San Diego American Indian Health Center for services provided to the patient.
- I further agree and acknowledge that my signature on this document authorizes San Diego American Indian Health Center to obtain and release any medical/dental/behavioral and billing information to Medi-Cal, Medicare and/or any other insurance necessary to process my claim(s), including determining eligibility and seeking reimbursement for services provided.
- If my insurance company reimburses me directly instead of San Diego American Indian Health Center, I will submit payment in the same amount to San Diego American Indian Health Center within thirty (30) days on my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center within thirty (30) days of my receipt of the payment.
- I am responsible for notifying San Diego American Indian Health Center if there is any change in my insurance, including the addition and/or loss of any insurance coverage. If I fail to notify the clinic of any such changes in insurance, I may be responsible for any charges as a result.
- Lab Work – I have the option of billing my services or paying for the cost of the labs at the time of the visit.
- I understand that I am responsible for the deductible non covered services and any balance due after insurance.
- I understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account.

_____

Name of Responsible Party (Please Print)

_____

Signature of Responsible Party Date

San Diego American Indian
HEALTH CENTER

HRN _____

Received By: _____

Date Entered: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received from the San Diego American Indian Health Center a Clinic Services Information brochure. This brochure contains general clinic services information which includes the following:

- Eligibility For Services
- Payment Policy
- Billing Inquiries
- Appointments Policy
- Appointment Cancellation Policy
- Late Arrival Policy
- Missed Dental Appointment Policy
- Medical/Dental/Behavioral Health Services Information
- Patient Rights and Responsibilities
- Other Services
- Notice of Privacy Practices
- Additional Uses of Information
- Dental Material Fact Sheet

_____

Patient Name (Please Print)

_____

Signature Date

Please complete reverse side

San Diego American Indian
HEALTH CENTER

Promoting Excellence in Health Care with Respect for Custom and Tradition

GENERAL CONSENT FOR TREATMENT & ASSIGNMENT OF BENEFITS

Patient's Name: _____ Chart Number: _____

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering the Center identified above and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include examination, radiological services, emergency services, laboratory procedures, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   The Center will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Center may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient. Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services:
   I, the undersigned, certify that the information given to the Center in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me, and authorize the Center to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Patient/Legal Representative

DATE:_____

SDAIHC - ADULT HEALTH HISTORY

Patient Name: _____ **DOB:** _____

My health concern today:

_____

_____

Major Past Illnesses: _____

Recent Hospitalizations or Surgery: _____

Current Medications List

MEDICATION NAME	DOSE / MG	Times per day	MEDICATION NAME	DOSE / MG	FREQUENCY

Allergies (especially medications):_____

Have you recently had any of the following exams?

Electrocardiogram ( ) Yes ( ) No Normal ( ) Yes ( ) No

Tuberculosis Test ( ) Yes ( ) No Normal ( ) Yes ( ) No

Lab Test ( ) Urine ( ) Stool Normal ( ) Yes ( ) No

Habits Tobacco ( ) Alcohol ( ) Drugs ( )

	YOU	YOUR FAMILY	Have you had:	YES	NO
DIABETES	____	____	WEIGHT LOSS	_____	____
HIGH BLOOD PRESSURE	____	____	SKIN LESIONS	_____	____
HEART DISEASE	____	____	VISUAL PROBLEMS	_____	____
TUBERCULOSIS	____	____	FREQUENT COLDS	_____	____
SEIZURES	____	____	DENTAL PROBLEMS	_____	____
ASTHMA/BRONCHITIS	____	____	HOARSENESS	_____	____
CANCER	____	____	BREAST NODULES	_____	____
HEPATITIS	____	____	DIFFICULTY BREATHING	_____	____
ANEMIA	____	____	PALPITATIONS	_____	____
ARTHRITIS	____	____	CHRONIC COUGH	_____	____
INTESTINAL PROBLEMS	____	____	CHEST PAIN	_____	____
EMOTIONAL PROBLEMS	____	____	SWALLOWING PROBLEMS	_____	____
ULCER DISEASE	____	____	DIARRHEA/CONSTIPATION	_____	____
THYROID DISEASE	____	____	BLOOD IN STOOL	_____	____
SEXUAL INFECTION	____	____	NAUSEA/VOMITING	_____	____
GLAUCOMA	____	____	PAIN ON URINATION	_____	____
STROKE	____	____	JOINT/BACK PAIN	_____	____
RHEUMATIC FEVER	____	____	CHRONIC HEADACHES	_____	____
GALLBLADDER STONES	____	____	DIZZY/WEAKNESS	_____	____
KIDNEY STONES	____	____	HEARING PROBLEMS	_____	____
OTHER PROBLEMS	____	____	SEXUAL CONCERNS	_____	____
			SLEEPING PROBLEMS	____	____

FOR WOMEN ONLY:

Last Menstrual Period: _____ Normal? ( ) Yes ( ) No Birth Control Method: _____

PATIENT SIGNATURE: _____

REVIEWED BY: _____ DATE: _____

TB EXPOSURE RISK ASSESSMENT

Patient's Name _____ HRN _____

Have you (Has the child) or anyone you see regularly been diagnosed or suspected of being sick with active TB disease?	□ Yes □ No
Do you (Does the child) or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?	□ Yes □ No
Do you (Does the child) have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, or parts of Eastern Europe?	□ Yes □ No
Were you (Was the child) born in, or travel to high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe?	□ Yes □ No
Do you (Does the child) live in out-of-home placements (such as board & care or residential facilities)?	□ Yes □ No
Do you (Does the child) have HIV infection, or another immunosuppressive condition?	□ Yes □ No
Do you (Does the child) live with someone who is HIV seropositive?	□ Yes □ No
Do you (Does the child) live, or frequently visit, with persons who have been incarcerated in the last 5 years?	□ Yes □ No
Do you (Does the child) live among or frequently been around individuals who are homeless, migrant workders, users of street drugs, or residents in nursing homes?	□ Yes □ No

CLINIC USE ONLY:

Administer a Mantoux TB skin test to adults or children who have any of the above risk factors (indicated by a Yes response) UNLESS:

1. The patient has a previously documented (including date performed, method of testing and millimeter reading) positive Mantoux TB skin test.
2. The patient has had a TB skin test within the last 12 months and has not had recent exposure to an individual with active TB.

Note: In accordance with AAP and CDC guidelines, only trained licensed personnel may read/interpret the skin test.

*Healthcare worker initials:*_____ *Date:*_____

HRN _____

REC'D BY _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby authorize San Diego American Indian Health Center to speak to the following individuals about my health and health record, including information regarding scheduling, billing and insurance. I understand that this does **not** include protected information regarding HIV, psychiatric, drug and/or alcohol records.

	NAME	DATE OF BIRTH
Spouse	_____	
Child	_____	
Child	_____	
Brother	_____	
Sister	_____	
Caregiver	_____	
Friend	_____	
Other	_____	
Other	_____	

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print) _____ Date of Birth _____

Patient Signature _____ Date _____

HRN #:_____
DATE: _____
NAME:_____

SECTION 1: PHQ-2 BEHAVIORAL HEALTH SCREEN

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things:**
    a. Not at all
    b. Several days
    c. More than half the days
    d. Nearly every day

2. **Feeling down, depressed or hopeless:**
    a. Not at all
    b. Several days
    c. More than half the day
    d. Nearly every day

SECTION 2: ALCOHOL SCREENING (AUDIT –C)

1. **How often do you drink alcohol?**
    a. Never
    b. Monthly or less
    c. 2 – 4 times a month
    d. 2 – 3 times a week
    e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
    a. 1 or 2
    b. 3 or 4
    c. 5 or 6
    d. 7 to 9
    e. 10 or more
3. **How often do you have six or more drinks on one occasion?**
    a. Never
    b. Less than monthly
    c. Monthly
    d. Weekly
    e. Daily or almost daily

PLEASE COMPLETE BACK SIDE

SECTION 3: TOBACCO USE SCREENING (please check the following)

Do you currently smoke or chew/dip tobacco?

____ YES, I USE TOBACCO ___SMOKE? ___ CHEW/DIP? ____BOTH?

____ OR YES, I USE TOBACCO FOR CEREMONIAL OR RELIGIOUS PURPOSES:

Method used? _____ (for example: pipe)

If YES: How many packs per day? _____ **OR** How much? _____ **AND How often?**

_____

Would you consider quitting? ___YES ___ NO

How can we help you quit? _____

____ NO, I HAVE **NEVER** SMOKED OR CHEWED TOBACCO.

____ NO, I DO NOT CURRENTLY USE TOBACCO (I have smoked or chewed tobacco in the past).

The last time I smoked was: ___within 0-6 months ___over 6 months ago

The last time I chewed/dipped was: ___within 0-6 months ___over 6 months ago

SECTION 4: DOMESTIC VIOLENCE SCREENING (please circle yes or no)

Do you ever feel afraid or threatened by your partner? YES NO

Within the last year have you been hit, slapped, kicked, or physically hurt by someone? YES NO

SECTION 5: DENTAL SCREENING

When was your last dental visit? _____ Where?

_____

☐ Patient refusal

Patient signature: _____ Date: _____