Anderson Valley Health Center

Patient Registration

Today's Date:_____

First Name:_____ Last Name:_____ Middle: _____

Social Security Number:_____ Date of Birth:_____ Gender: ☐M ☐F

House Phone:_____ Cell phone:_____ Work Phone:_____

Street Address:_____ City:_____ Zip code:_____

Mailing Address:_____ City:_____ Zip code:_____

State:_____ Email:_____ Preferred Language:_____

Would you like to be enrolled in our online Patient Portal? ☐Yes ☐No

Responsible Party Information

Person responsible for payment (if not self):_____

Date of Birth: _____

Relationship: _____

Address: _____ City: _____ Zip code: _____

☐ Ok to leave a message with who answers the phone ☐ Ok to leave message on answering machine

☐ Do not call under any circumstances (*if checked) Alternative contact required:* _____

Ethnicity/Race:

☐ Hispanic/Latino ☐ Native American ☐ White ☐ Asian ☐ Native Hawaiian

☐ Pacific Islanders ☐ Refuse to answer ☐ African American ☐ Alaskan Native ☐ Other:_____

Marital Status:

☐ Single ☐ Single w/Partner ☐ Separated

☐ Married ☐ Widowed ☐ Divorced

Are you a Student? (Part Time Or Full Time?)	☐Yes ☐No	Are you a Veteran?	☐Yes ☐No
Are you a Seasonal worker? (Lives here full-time)	☐Yes ☐No	Are you a Migrant worker? (Lives here part-time)	☐Yes ☐No

Primary Insurance:

☐ Partnership ☐ Medicare ☐ Medi-Cal ☐ Cover California ☐ No Insurance

☐ Other Insurance: _____ Subscriber ID Number: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____
(First and last)

Information About Patient And Insurance

Gross Annual Income: ☐ $0- $15,999 ☐ $16,000- $21,000 ☐ $22,000- $30,999 ☐ $31,000 +

Are you Homeless? ☐ Yes ☐ No Family Size: _____

If yes, what are you current living conditions?

☐ Shelter ☐ Street Campground ☐ Transitional Housing ☐ Doubling up (Family or Friend) ☐ Other: _____

Please fill out the other side.

Work information:

Employers Name: _____

Work Number:_____ Cell Phone: _____

Address: _____ City:_____ Zip code:_____

Medical History

Information of Previous or Current Physician:

Physicians Name:_____

Phone: _____ Fax: _____

Address:_____ City: _____ Zip code:_____ State: _____

Questions about yourself:

When was your last Physical? _____

Are your immunizations up to date? ☐ Yes ☐No

Are you under the care of a physician? ☐ Yes ☐No

If yes, for what reason? _____

Are you currently taking any medications/drugs? ☐ Yes ☐No

Please list them here: _____

Are you allergic (or have an adverse reaction) to any of the following? *:*

Penicillin: ☐ Yes ☐No Codeine: ☐Yes ☐No Local Anesthetic: ☐Yes ☐No Aspirin: ☐Yes ☐No

None: ☐ Other: ☐Yes ☐No If you answered other, which:_____

Are you sensitive or allergic to latex? *(I.e. itching, rash, or wheezing after using latex gloves/ handling a balloon?)* ☐Yes ☐No

If yes, please explain: _____

Have you ever had any unusual or unexplained reactions during surgical procedures? ☐ Yes ☐No

If yes, please explain: _____

Do you have, or have had any of the following?

☐Yes ☐No	Alcohol Addiction	☐Yes ☐No	Arthritis / Rheumatism	☐Yes ☐No	Anemia
☐Yes ☐No	Artificial joint	☐Yes ☐No	Anorexia	☐Yes ☐No	Asthma
☐Yes ☐No	Abnormal Blood Pressure	☐Yes ☐No	Artificial Heart Valve	☐Yes ☐No	Arm Removal
☐Yes ☐No	Bulimia	☐Yes ☐No	Cancer	☐Yes ☐No	Cortisone Medicine
☐Yes ☐No	Congenital Heart Defects	☐Yes ☐No	Chemical Dependency	☐Yes ☐No	Chemotherapy
☐Yes ☐No	Diabetes	☐Yes ☐No	Epilepsy	☐Yes ☐No	Emphysema
☐Yes ☐No	Fainting	☐Yes ☐No	Glaucoma	☐Yes ☐No	Heart Disease / Heart Surgery
☐Yes ☐No	Heart Murmur	☐Yes ☐No	Hard of Hearing	☐Yes ☐No	Hepatitis A_____ B_____ C_____
☐Yes ☐No	Hemophilia	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Liver Disease
☐Yes ☐No	Learning Problem	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Neurological Disorders
☐Yes ☐No	Osteoporosis	☐Yes ☐No	Organ Transplantation	☐Yes ☐No	Prosthetic implants
☐Yes ☐No	Positive HIV / AIDS	☐Yes ☐No	Prolonged bleeding	☐Yes ☐No	Pulmonary disease
☐Yes ☐No	Psychiatric Treatment	☐Yes ☐No	Pacemaker	☐Yes ☐No	Rheumatic Fever
☐Yes ☐No	Recreational Drugs	☐Yes ☐No	Radiation Therapy	☐Yes ☐No	Rheumatic Heart Disease by
☐Yes ☐No	Sinusitis	☐Yes ☐No	Sickle Cell Anemia	☐Yes ☐No	Stroke
☐Yes ☐No	Thyroid Problem	☐Yes ☐No	Tumors	☐Yes ☐No	Tuberculosis
☐Yes ☐No	Ulcers	☐Yes ☐No	Venereal diseases		

Have you had any other serious illness, Hospitalization or accident? ☐Yes ☐No
If yes, please explain: _____

Do you currently smoke or use the following tobacco products?
Cigarettes_____ Cigars_____ Pipe_____ Chew_____ None_____

Have you used tobacco products in the past? ☐Yes ☐No
If yes, how long ago: _____

Do you drink alcoholic beverages? ☐Yes ☐No
If yes, how much: _____

Women: (Only Women)

Are you pregnant?	☐Yes ☐No	Are you nursing?	☐Yes ☐No
Do you take birth control medications?	☐Yes ☐No	Do you anticipate becoming pregnant?	☐Yes ☐No
Number of pregnancies:_____		Number of living children:_____	

Dental History

(For Dental Only)

Date of last visit: _____		Do your gums bleed while brushing or flossing?	☐Yes ☐No
Are your teeth sensitive to hot or cold liquids/foods?	☐Yes ☐No	Do you feel pain in any of your teeth?	☐Yes ☐No
Do you have any sores or lumps in or near your mouth?	☐Yes ☐No	Are your teeth sensitive to sweet or sour liquids/food?	☐Yes ☐No
Have you had any head, neck, or jaw injuries?	☐Yes ☐No	Do you have frequent headaches?	☐Yes ☐No
Do you clench or grind your teeth?	☐Yes ☐No	Do you bite your lips of cheeks frequently?	☐Yes ☐No
Have you had any orthodontic work?	☐Yes ☐No	Have you ever had prolonged bleeding following extractions?	☐Yes ☐No
Have you ever had instructions on the correct method of brushing your teeth?	☐Yes ☐No	Have you ever had instruction on the care of your gums?	☐Yes ☐No

Have you ever experienced the following?

Clicking Jaw_____ Pain (joint, ear, side of face) _____

Difficulty in opening or closing mouth_____ Difficult in chewing_____

TREATMENT CONDITIONS

Consent to Treatment: The undersigned hereby consent to the administration and performance of all diagnostic procedures and treatment, which, in the judgment of the physician assistant/nurse practitioner/ dentist may be considered necessary

Medicare Assignment: I certify that the information given to me in applying or payment under Title VII of the Social Security Act is correct. I request that payment of the authorized benefits be made in my behalf.

Assignment of Insurance Benefits: In the event I am entitled to benefits arising out of any policy of insurance insuring me or any party liable to me. I hereby assign said benefits directly to Anderson Valley Health Center for application to my bill. I agree that Anderson Valley Health Center may issue a receipt for any such payment, that payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment, and that I shall be responsible for changes not covered by the agreement.

Patient's Signature: _____ Date: _____

☐Parent ☐Guardian (specify relationship):_____ Date: _____

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR MEDICAL CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individual identifiable health information ("protected health information") by AVHC Medical in order to carry out treatment, payment or health care operations. The patient has received the AVHC Medical Notice of Privacy Practices for Protected Medical Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such notice prior to signing this consent form.

AVHC Medical reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Medical Information at any time. If AVHC Medical does change the terms of its Notice of Privacy Practices, patient may obtain a copy of the revised notice.

Patient retains the right to request that AVHC Medical further restrict how his/her protected health information is used or disclosed to carry out treatment, payments, or health care operations. AVHC Medical is not required to agree to such requested restrictions; however, if AVHC Medical does agree to patient's requested restriction(s) such restrictions are the binding on AVHC Medical.

At all time, patient retains the right to revoke this consent. Such revocation must be submitted to AVHC Medical in writing. The revocation shall be effective except to the extent that AVHC Medical has already taken action in reliance on the consent.

AVHC Medical may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form (except to the extent that AVHC Medical is required by law to treat individuals). If the patient signs this consent form and then revokes consent , AVHC Medical has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that AVHC Medical is required by law to treat individuals).

I have read and understand this information. I have received a copy of this form, the AVHC Privacy Practices for Protected Health Information and I am the patient or an authorized representative to act on behalf of patient to sign this document verifying consent to the above stated terms.

Date:_____ Time: _____ A.M./ P.M.

_____ _____
Signature of Patient Please Print Name

_____ _____
Person Signing on Behalf of Patient* Please Print Name of Representative

_____ _____
Witness Signature Please Print Name of Witness

Please explain below the relationship to patient and include a description of representative's authority to act on behalf of the patient.

_____

_____

_____

_____