



New Patient Registration

Today's Date: ____/____/____

Gender Identity:			Sexual Orientation:		
<input type="checkbox"/> Male	<input type="checkbox"/> Transgender	<input type="checkbox"/> Female to If Yes: Male	<input type="checkbox"/> Straight (not lesbian/gay)	<input type="checkbox"/> Lesbian/Gay	<input type="checkbox"/> Choose not to Disclose
<input type="checkbox"/> Female	<input type="checkbox"/> Decline	<input type="checkbox"/> Male to Female	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Something Else	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Other					

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

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

DOB: ____/____/____ Social Security Number: ____-____-____

Home Phone: (____) ____-____ Cell phone: (____) ____-____ Work Phone: (____) ____-____

Preferred Time to Call: Morning Afternoon Best way to Contact: Voice Email Portal

Email: _____ Enroll in our Patient Portal? Yes No Already Enrolled

Information about Patient:

Gross Annual Income: \$0 - \$20,000 \$20,000 - \$30,000 \$30,000 - \$40,000 \$40,000 +

Family Size: _____ Are Homeless? Yes No

If Yes: Shelter Street Campground Transitional Housing Doubling up (Family or Friend)

Marital Status:

- Single Married
 Separated Single w/ Partner
 Divorced Widow

More Information:

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

Ethnicity/Race: (check all that apply)

- Hispanic/Latino Native American White Asian Native Hawaiian
 Pacific Islanders Refuse to answer African American Alaskan Native Other: _____

Information on Responsible Party for Payment: (if not self)

Name: _____ DOB: ____/____/____ Relationship: _____ Phone Number: (____) ____-____

Check all that that apply:

- Ok to leave message with whom answers phone Ok to leave voice mail

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

Primary Insurance:

Partnership Medicare Medi-Cal Covered California Other Insurance: _____
Subscriber ID Number: _____ No Insurance

Emergency Contact:

Name: _____ Relationship: _____ Telephone: (_____) _____ - _____

Employer's information:

Employers Name: _____ Work Number: (_____) _____ - _____ Fax: (_____) _____ - _____
Address: _____ City: _____ State: _____ Zip code: _____

Medical History: (Information of Previous or Current Physician)

Physicians Name: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
Address: _____ City: _____ State: _____ Zip code: _____

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

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

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:

- | | | |
|-------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> None | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Other Name of Other: _____ |

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

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

If yes, please explain: _____

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: _____ Months/Weeks/Days/Hours

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

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 or 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 any of the following symptoms?

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.***

