

**New Patient Registration**

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| --- | --- | --- | --- |
| Today’s Date: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | Are you a Veteran? | □ Yes | □ No |
| First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Middle Initial: \_\_\_\_\_\_ | Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ | Social Security Number: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ |
| Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_ | Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_ | Zip code: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Home#: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | Cell#: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | Work#: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |
| If you cannot be reached, is it? | □ Ok to leave message with whom answers phone | □ Ok to leave voice mail |
| Best form of Contact: | □ Email | □ Voice | □ Portal | Best Time to Call: | □ Morning  | □ Afternoon | □ No Call |
| Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Enroll in our Patient Portal? | □ Yes | □ No | □ Already Enrolled |
| **Gender Identity:** | □ Male | □ Female | □ Transgender: | * Female to Male
* Male to Female
 | □ Other | □ Decline |
| **Sexual Orientation:** | □ Straight ( not lesbian/gay  | □ Lesbian/Gay | □ Bisexual |
|  | □ Other | □ Choose not to Disclose | □ Don’t Know |
| **Emergency Contact:** | Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone#: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | □ Ok to leave voice mail | □ Ok to leave message with whom answers phone |
| **Information on Responsible Party for Payment:** (if not self) | Relation: \_\_\_\_\_\_\_\_\_\_\_\_ | DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ |
| Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone Number: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_\_ | Zip code: \_\_\_\_\_\_\_\_\_ |
| **Primary Insurance:** | □ Covered CA: Blue-Shield/Blue-Cross | □ Medicare | □ Medi-Cal | □ Partnership Health Care |
| Other Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Subscriber ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ None |
| **Family Gross Annual Income:**# Of People Living in Home: \_\_\_\_\_\_\_ | □ $0 - $20,000 | □ $20,000 - $30,000 | □ $30,000 - $40,000 | □ $40,000 + |
| **Are You Homeless:** | □ Yes | □ No | □ Shelter | □ Street Campground | □ Family/Friend | □ Transitional Housing |
| **Marital Status:** | □ Single | □ Married | □ Widow | □ Divorced | □ Separated | □ Domestic Partner |
| **Ethnicity/Race:**(check all that apply) | □ Refuse to answer | □ White | □ Hispanic/Latino  | □ Asian | □ Native Hawaiian |
| □ Native American | □ Pacific Islanders | □ Alaskan Native | □ African American | □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Employer’s information:** | Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_ | Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you a Student? | □ Yes | □ No | If Yes, are you Full Time or Part Time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you a Migrant worker? | □ Yes | □ No | If yes, are you living here Full Time or Part Time? \_\_\_\_\_\_\_\_ |
| Are you a Seasonal worker? | □ Yes | □ No | If yes, are you living here Full Time or Part Time? \_\_\_\_\_\_\_\_ |
| **Medical History:** (Information of Previous or Current Physician) | Physicians Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City: \_\_\_\_\_\_\_\_\_\_\_\_\_ | State: \_\_\_\_\_\_\_ | Zip code: \_\_\_\_\_\_\_\_\_\_\_ |
| 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 sensitive/allergic to latex? (I.e. itching, rash, or wheezing after using latex gloves/handling a balloon) | □ Yes | □ No |
| Are you allergic or have an adverse reaction to any of the following: | 🗆 Other Name Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🗆 Penicillin | 🗆 Amoxicillin | 🗆 Latex | 🗆 Narcotics | 🗆 Codeine | 🗆 Aspirin | 🗆 Local Anesthetic | 🗆 None |
| Have you had any other serious illness, Hospitalization or accident? | □ 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 drink alcoholic beverages? | □ Yes | □ No | If yes, how many a day do you drink: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you used tobacco products in the past? | □ Yes | □ No | If yes, how long ago: \_\_\_\_\_\_\_\_\_\_\_\_Hours/Days/Weeks/Months |
| Do you currently (or have in the past year) smoke or use any of the following tobacco products? | 🗆 Cigarettes | 🗆 Cigars | 🗆 Pipe | 🗆 Chew | 🗆 None |
| Do you have, or have had any of the following? |
| Sinusitis | □ Yes | □ No | Abnormal Blood Pressure | □ Yes | □ No | Radiation Therapy | □ Yes | □ No |
| Cancer | □ Yes | □ No | Hepatitis A\_\_\_\_ B\_\_\_\_\_ C\_\_\_\_ | □ Yes | □ No | Artificial Joint | □ Yes | □ No |
| Ulcers | □ Yes | □ No | Arthritis / Rheumatism | □ Yes | □ No | Thyroid Problem | □ Yes | □ No |
| Stroke | □ Yes | □ No | Psychiatric Treatment | □ Yes | □ No | Tuberculosis | □ Yes | □ No |
| Anemia | □ Yes | □ No | Chemical Dependency | □ Yes | □ No | Venereal diseases | □ Yes | □ No |
| Bulimia | □ Yes | □ No | Rheumatic Heart Disease | □ Yes | □ No | Pulmonary disease | □ Yes | □ No |
| Diabetes | □ Yes | □ No | Neurological Disorders | □ Yes | □ No | Prosthetic implants | □ Yes | □ No |
| Fainting | □ Yes | □ No | Heart Disease / Heart Surgery | □ Yes | □ No | Kidney Problems | □ Yes | □ No |
| Tumors | □ Yes | □ No | Positive HIV / AIDS | □ Yes | □ No | Anorexia | □ Yes | □ No |
| Epilepsy | □ Yes | □ No | Heart Murmur | □ Yes | □ No | Learning Problem | □ Yes | □ No |
| Asthma | □ Yes | □ No | Cortisone Medicine | □ Yes | □ No | Recreational Drugs | □ Yes | □ No |
| Osteoporosis | □ Yes | □ No | Prolonged bleeding | □ Yes | □ No | Chemotherapy | □ Yes | □ No |
| Emphysema | □ Yes | □ No | Alcohol Addiction | □ Yes | □ No | Liver Disease | □ Yes | □ No |
| **For Women Only:** | Number of pregnancies: \_\_\_\_\_\_\_\_\_ | Number of living children: \_\_\_\_\_\_\_\_\_ |
| Are you pregnant? | □ Yes | □ No | Do you plan to become pregnant? | □ Yes | □ No |
| Do you take birth control medications? | □ Yes | □ No | Are you nursing? | □ Yes | □ No |
| **Dental History:** | Date of last Dental visit: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Have you ever experienced any of the following symptoms? |
| 🗆 Pain (ear/side of face)  | 🗆 Difficulty in opening or closing mouth  | 🗆 Difficult in chewing | 🗆 Clicking of the Jaw  |
| Have you ever had instructions on the correct method of brushing your teeth? | □ Yes | □ No |
| Are your teeth sensitive to hot/cold liquids/foods? | □ Yes | □ No |
| Do you have any sores/lumps in/near your mouth? | □ Yes | □ No |
| Are your teeth sensitive to sweet/sour liquids/food? | □ Yes | □ No |
| Have you ever had prolonged bleeding following extractions? | □ Yes | □ No |
| Have you ever had instruction on the care of your gums? | □ Yes | □ No |
| Do you feel pain in any of your teeth? | □ Yes | □ No |
| Do you clench/grind your teeth? | □ Yes | □ No |
| Have you had any orthodontic work? | □ Yes | □ No |
| Do you have frequent headaches?  | □ Yes | □ No |
| Have you had any head/neck/jaw injuries? | □ Yes | □ No |
| Do you bite your lips/cheeks frequently? | □ Yes | □ No |
| Do your gums bleed when brushing/flossing? | □ Yes | □ No |
| **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:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| **If minor, please check appropriate box:** 🗆 Parent 🗆 Guardian | **Specify Relation to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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.* |
| **Patient’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date:** \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| **If minor, please check appropriate box:** 🗆 Parent 🗆 Guardian | **Specify Relation to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |