**New Patient Registration**

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| Date: | Preferred Spoken Language: | English | Spanish | Other: |
| Name: Middle: Last: |
| DOB: Social Security Number: | Veteran: | Y | N |
| Home Address: City: State: Zip Code: |
| Mailing Address: City: State: Zip Code: |
| Home#: Cell#: Work#: |
| If you can’t be reached, is it OK to leave: | Verbal message with whomever answers the phone | Voice Mail |
| Best time to call you: | AM | PM | Appt. Reminders: | Y | N | Best way to contact you: | Voice |
| Text (Only for appt. reminders) | Email: | Online Portal: | Y | N |
| Gender Identity: | Male | Female | Transgender | * Female to Male
* Male to Female
 | Gender non-conforming | Choose not to Disclose |
| Sexual Orientation: | Straight(Not Les./Gay) | Lesbian/Gay | Bisexual | Don’t Know | Gender non-conforming | Choose not to Disclose |
| Ethnicity/Race: | Caucasian | Hispanic or Latino | Asian | African American | Native: |
| Other: | Choose not to Disclose | Marital Status: | Single | Married | Widow |
| Divorced | Separated | Domestic Partner | Primary Insurance: | Medi-Cal/Partnership | Medicare |
| CoveredCA | Other Member ID#: | None |
| Secondary Insurance: | Medi-Cal/Partnership | Medicare | CoveredCA | Other: |
| Member ID#: | None | # of People living in Household: |
| Family Gross Annual Income: | $0 - $20,000 | $20,000 - $30,000 |  $30,000 - $40,000 | $40,000 + |
| Responsible for Payment:(If not Self) | Relation: Full Name: DOB: |
| Phone#: | Ok to leave Voice Mail | Ok to leave Verbal Message with Contact |
| Mailing Address: City: State: Zip Code: |
| Emergency Contact: | Relation: Full Name: DOB: |
| Phone#: | Ok to leave Voice Mail | Ok to leave Verbal Message with Contact |
| Are you Homeless: | Y | N | If yes: | Shelter | Street Campground | Family/Friend | Transition Housing |
| Are you a Student: | Y | N | If yes: | Full Time | Part Time | Are your IZ’s up to date: | Y | N | Don’t Know |
| Are you a Migrant Worker: | Y | N | If yes: | Full Time | Part Time | Are you a Seasonal Worker: | Y | N | If yes: | Full Time | Part Time |
| Are you currently under the care of a Primary Care Provider: | Y | N | If yes, why: |
| Full Name: Dr. Phone#: Fax#: |
| Mailing Address: City: State: Zip Code: |
| Currently taking any Medication/Drugs: | Y | N | If yes, which: |
| Allergic or have had an adverse reaction to any of the following: | None | Aspirin | Latex | Penicillin’s |
| NSAIDS | Local Anesthetics | Sulfa | Narcotics | Other: | Unusual or unexplained |
| reactions during surgical procedures: | Y | N | If Yes, explain: |
| Accidents or Hospitalized: | Y | N | If Yes, when: |
| Do you drink alcoholic beverages: | Y | N | If yes, how many a day: | Have you used tobacco products in the past: | Y | N |
| If yes, when: | What: | Cigarettes | Cigars | Pipe | Chew | Other: |
| Do you have, or have had any of the following: (Please check all the ones that apply to you) | Cancer | Ulcers |
|  Venereal Disease | Anorexia/Bulimia | Abnormal Blood Pressure | Stroke | Heart Valve |
|  Abnormal Pap |  Radiation Therapy |  Rheumatic Heart Disease | Fibroids | Anemia |
|  Liver Disease |  Neurological Disorders | Hepatitis A\_\_\_B\_\_\_C\_\_\_ | Asthma | Sinusitis |
|  Artificial Joint |  Prosthetic implants | Positive HIV/AIDS | Tuberculosis | Fainting |
| Thyroid Problem |  Pulmonary Disease |  Recreational Drugs | Diabetes | Epilepsy |
| Learning Problem | Arthritis/Rheumatism | Prolonged bleeding | Splenectomy | Osteoporosis |
| Alcohol Addiction  | Chemical Dependency | Pacemaker/Defibrillator | Glaucoma | Heart Murmur |
|  Kidney Problems  | Psychiatric Treatment | Heart Disease/Surgery | Emphysema | Chemotherapy |
| Date of Last Physical: | The following questionnaire is directed for Women only: |
| Number of pregnancies: | Are you pregnant: | Y | N | Do you plan to become pregnant: | Y | N |
| Number of living children: | Are you nursing: | Y | N | Do you take birth control medications: | Y | N |
| Dental Use Only: | Date of last visit: | Have you experienced any of the following: |
| Pain (ear/side of face)  | Difficulty in opening or closing mouth  | Sensitive to sweet/sour liquids/food |
| Frequent headaches | Sensitive to hot/cold liquids/foods | Bleeding gums when brushing/flossing |
| Difficulty in chewing | Biting your lips/cheeks frequently | Prolonged bleeding following extractions |
| Clicking of the Jaw  | Pain in any of your teeth | Sores/lumps in or near your mouth |
| Head/neck/jaw injuries | Clenching/grinding of your teeth | Other: |
| Have you ever had instructions on the correct method of brushing your teeth: | Y | N | Have you ever had instruction on the care of your gums: | Y | N |
| Have you had any orthodontic work: | Y | N |  |
| **TREATMENT CONDITIONS** |
| **Consent to Treatment:** The undersigned hereby consents to the administration and performance of all diagnostic procedures and treatment, which, in the judgment of the provider 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 from any insurance policy 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. |
| **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 in order to carry out treatment, payment or health care operations. The patient has received the AVHC Notice of Privacy Practices for Protected 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 reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Information at any time. If AVHC 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 further restrict how his/her protected health information is used or disclosed to carry out treatment, payments, or health care operations. AVHC is not required to agree to such requested restrictions; however, if AVHC does agree to patient’s requested restriction(s) such restrictions are the binding on AVHC.At all times, patient retains the right to revoke this consent. Such revocation must be submitted to AVHC in writing. The revocation shall be effective except to the extent that AVHC has already taken action in reliance on the consent.AVHC may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form (except to the extent that AVHC is required by law to treat individuals). If the patient signs this consent form and then revokes consent, AVHC has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that AVHC is required by law to treat individuals). |
| ***I have read and understand this information. I understand I can request 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: Today’s Date: |
| If minor, please check appropriate box: | Parent | Guardian | Relation to Patient: |