Patient Registration

Would you like assistance filling out this form? □ Yes □ No

Date: _____ **DOB:** _____ **SS#:** _____

Legal Last Name: _____ **Legal First Name:** _____**Middle Initial**: _____

Preferred Name: _____ **Preferred Pronouns** (he, she, they): _____

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

Physical Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Numbers

Home: _____ **Cell:** _____ **Work:** _____

Best way to contact you: □ Home □ Cell □ Text

Email: _____ **Enroll in Patient Portal?** □ Yes □ No

Emergency Contact & the best way to contact this person:

Last Name: _____ First Name: _____ Relationship: _____

Phone#: _____ Other: _____

Primary Care Physician (PCP)

□ John Rochat (MD) □ Cindy Novella (FNP) □ Cary Smeltzer (DO) □ Jess Dawdv (FNP)

□ PCP not at this clinic: _____

Are you financially responsible for visits? □ Yes □ No If no, Complete the following:

Last Name: _____ First Name: _____ Relationship to patient: _____

Mailing Address: _____City: _____ State: _____ Zip:_____

Best way to contact this person: Phone#: _____ Other: _____

Insurance Coverage: □ Yes □ No If so, please present Insurance Card to the front desk

□ Self Pay □ I would like to apply for Medi-Cal or Sliding Scale

Primary Medical Insurance: □ Medi-Cal/Partnership □ Medicare □ Private: _____
ID/Subscriber#: _____ Plan/Group#: _____

Secondary Insurance: □ Medi-Cal/Partnership □ Medicare □ Private: _____
ID/Subscriber#: _____ Plan/Group#: _____

Dental Insurance: _____

ID/Subscriber#: _____ Plan/Group#: _____

Household Income (for grant purposes)**:**

Number of dependents including yourself: _____ Family yearly Income before Taxes? $_____

Primary Spoken Language: □ English □ Spanish □ Other

Do you need a translator for you visits? □ Yes □ No

I am requesting assistance with meeting the following needs (check all that apply):

□ Vision □ Mobility □ Hearing

*** Our mission is to provide excellent and affordable care to the community of Anderson Valley and beyond. ***
*** AVHC is an equal opportunity provider and employer. ***

Patient's Sex at Birth:
- ☐ Male
- ☐ Female
- ☐ Intersex

Sexual Orientation:
- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bisexual
- ☐ Do not know
- ☐ Choose not to disclose
- ☐ Something else,
  Please describe: _____
  _____

Gender Identity:
- ☐ Female / Woman
- ☐ Male / Man
- ☐ Transgender Male/Trans Man
- ☐ Transgender Female/Trans Woman
- ☐ Genderqueer / Gender nonconforming
- ☐ Choose not to disclose
- ☐ Additional gender category or other:
  _____

Ethnicity:
- ☐ Mexican, Mexican American, Chicano
- ☐ Cuban
- ☐ Puerto Rican
- ☐ Other Hispanic, Latino/a, or Spanish Origin
- ☐ Non-Hispanic or Latino
- ☐ Unknown
- ☐ Refuse to report

Race (check all that apply)**:**
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ African American / Black
- ☐ American Indian/Alaska Native
- ☐ Caucasian/White
- ☐ Choose not to disclose
- ☐ Other: _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian: _____

The following questions are to help you and your community:

Anderson Valley Health Center is a not-for-profit corporation. The grants we get help us give services to people who can't afford to pay full cost. Answering these questions will help us serve you AND your community.

Check all that apply to you:
- ☐ Veteran
- ☐ Seasonal agricultural worker:
  Example: My main job is agriculture, and I don't work year-round.
- ☐ Migrant agricultural worker:
  Example: My main job is agriculture; I don't work year-round, and I move to find my jobs.
- ☐ Living in transitional housing:
  It is a temporary housing program with help to later transition into permanent housing.
- ☐ Living in a homeless shelter
- ☐ Living on the street or in my car
- ☐ Staying temporarily with friends/family
- ☐ Other housing situation:
  Please describe: _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

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 application or payment under Title VII of the Social Security Act is correct. I request that payment of the authorized benefits be made on 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 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 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, patients 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 binding on AVHC.

At all times, the 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 acted in reliance on the consent.

AVHC may refuse to treat a 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.

Print Full Name: _____ Date: _____

Patient Signature: _____

If minor, parent/Guardian Signature: _____

Print Full Name: _____ Date: _____

Medical History Date you had your last Physical (H&P): _____

Currently taking any Medications/Drugs: □ Yes □ No

If yes, what: _____

Allergic or have had an adverse reaction to any of the following:

□ Aspirin □ Latex □ Penicillin □ Sulfa □ NSAIDS □ Local Anesthetics □ Narcotics □ None that I know of □ Other: _____

Unusual or unexplained reactions during surgical procedures: □ Yes □ No

If yes, explain: _____

Have you been in an accident or hospitalized recently: □ Yes □ No

If yes, explain: _____

Do you drink alcoholic beverages: □ Yes □ No If yes, how many a day: _____

Do you or have you used tobacco products: □ Yes □ No

If yes, when was the last time: _____

What: □ Cigarettes □ Cigars □ Pipe □ Chew □ Vape □ Other: _____

Do you have or have you had any of the following:
(Please check all that apply):

			□ Pacemaker/ Defibrillator	□ Ulcers
□ Glaucoma	□ Anorexia/Bulimia	□ Abnormal Blood Pressure	□ Abnormal Pap	□ Fibroids
□ Cancer	□ Radiation Therapy	□ Rheumatic Heart Disease	□ Artificial Joint	□ Anemia
□ Liver Disease	□ Recreational Drugs	□ Arthritis/Rheumatism	□ Chemotherapy	□ Sinusitis
□ Heart Valve	□ Prosthetic implants	□ Positive HIV/AIDS	□ Thyroid Problem	□ Fainting
□ Tuberculosis	□ Pulmonary Disease	□ Neurological Disorders	□ Heart Murmur	□ Epilepsy
□ Splenectomy	□ Hepatitis A B C	□ Chemical Dependency	□ Learning Problem	□ Stroke
□ Emphysema	□ Prolonged bleeding	□ Heart Disease	□ Alcohol Addiction	□ Diabetes
□ Osteoporosis	□ Psychiatric Treatment	□ Venereal Disease	□ Kidney Problem	□ Asthma

Questionnaire for Women Only:

# of pregnancies: _____ Are you pregnant? □ Y □ N Do you plan to become pregnant? □ Y □ N

# of living children: _____ Are you nursing? □ Y □ N Are you taking Birth Control Med? □ Y □ N

Date of last visit: _____

Dental History:

Have you ever gotten instructed on the correct method of brushing your teeth? □ Yes □ No

Have you ever gotten instructed on the correct method for caring for your gums? □ Yes □ No

Have you ever had any orthodontic work? □ Yes □ No

Have you experienced any of the following?

□ Pain (ear or side of face)
□ Pain/Sensitive teeth
□ Frequent headaches
□ Difficulty chewing
□ Clicking of the jaw
□ Head/neck/jaw injuries
□ Sensitive to hot/cold liquids/foods
□ Sensitive to sweet/sour liquids/food
□ Biting your lips/cheeks frequently
□ Sores/lumps in or near your mouth
□ Difficulty opening/closing mouth
□ Clenching/grinding of the teeth
□ Bleeding gums when brushing/flossing
□ Prolonged bleeding following extraction
□ Other: _____