Mountaineer Community Health Center

Patient Registration

PATIENT INFORMATION			
Patient's Name (Last, First Middle):		Birth date: / /	Birth Sex:
Home Phone:	Cell Phone:	Work Phone:	Social Security No.
Street Address:			
City:	State:	Zip Code:	
Email Address:	Marital Status		

FOR PATIENTS UNDER 18			
Mother's Name:	Date of Birth: / /	Day Phone:	Evening Phone:
Address:	City:	State:	Zip Code:
Father's Name:	Date of Birth: / /	Day Phone:	Evening Phone:
Address:	City:	State:	Zip Code:

IN CASE OF EMERGENCY			
Name:	Relationship:	Home Phone:	Cell Phone:

INFORMATION RELEASE	
I give my **permission to release medical and billing information** to the following individuals listed below. (Could include spouse, parent, grandparent, child and/or sibling, etc.) You do **not** have to select anyone. Please list name and relationship.	
1.	2.
3.	4.

BILLING INFORMATION			
Send Bill to:		Relationship to Patient:	
Address:	City:	State:	Zip Code:

HOW DID YOU HEAR ABOUT US?			
Friend		Family	
Newspaper (specify)	Radio (specify)	Billboard	Other (specify)

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DEMOGRAPHIC INFORMATION

To assist us in your determining eligibility for other programs, and providing statistical information to our federal and state grant agencies, please provide us with the following information:

Number in Household:	Household Income:	Per: □ Year □ Month	Have you ever been discharged from the military? □ Yes □ No

Are you homeless? □ Yes □ No	Are you a migrant / seasonal worker? □ Yes □ No	What is your preferred language? □ English □ Spanish □ Other: _____

Are you Hispanic? □ Yes □ No □ Prefer not to disclose	Race (check all that apply): □ White □ Black / African American □ Native Hawaiian □ Other Pacific Islander □ Asian □ American Indian / Alaska Native □ Prefer not to disclose

What is your current gender identity? (check all that apply) □ Male □ Transgender Male / Trans Man / Female-to-Male □ Female □ Transgender Female / Trans Woman / Male-to-Female □ Genderqueer, neither exclusively male nor female □ Decline to answer □ Something Else: _____	Do you think of yourself as: □ Straight or Heterosexual □ Bisexual □ Lesbian, Gay, or Homosexual □ Don't know □ Something Else: _____

CONSENT AND AUTHORIZATION

I hereby give **consent for treatment** to the health care providers of the Mountaineer Community Health Center. I authorize third party payers, such as insurance companies, Medicare, and Medicaid, to issue payments directly to Mountaineer Community Health Center for benefits otherwise payable to me. I understand that **I am responsible for all costs** of treatment including services not covered by insurance.

_____ _____

Patient/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I certify that I have received a copy of Mountaineer Community Health Center's Notice of Privacy Practices. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of my bills, or in the performance of Mountaineer Community Health Center's health care operations and for other purposes that are permitted or required by law. It also describes my rights to access and control my protected health information. The Notice of Privacy Practices is also posted in the waiting areas of Mountaineer Community Health Center.

I understand that Mountaineer Community Health Center uses electronic systems to allow protected health information to be shared between Mountaineer Community Health Center's providers and other providers involved in my treatment such as specialists, hospitals, and pharmacies. I understand that I have the right to opt out of participation in these systems at any time by notifying Mountaineer Community Health Center in writing.

I understand that Mountaineer Community Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practice by calling the Mountaineer Community Health Center office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient/Guardian signature *Date*

Mountaineer Community Health Center

PATIENT HISTORY FORM

MUST BE COMPLETED PRIOR TO CHECK-IN

Date: _____/_____/_____

NAME: _____ Age:_____ Sex: ❑ F ❑ M
Last First M. I.

Birthdate: _____/_____/_____

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen:

Preferred Pharmacy:

CURRENT MEDICATIONS

Medication allergies: ❑ No ❑ Yes To what? _____Reaction:_____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:
(USE BACK FOR ADDITIONAL SPACE IF NEEDED)

Name of Medication	**Dose (include strength & number of pills per day)**	**How long have you been taking this?**
1.		
2.		
3.		
4.		

Immunizations History: Date Last Received: Pnuemonia? _____ Tdap? _____ Flu? _____ Shingles? _____

PAST MEDICAL AND FAMILY HISTORY

Do you or someone in your family have or has had:

If not you, who was diagnosed (i.e. mother; father; grandmother; grandfather; sibling; aunt; uncle)	Living or Deceased? (circle one)	Deceased Age:
❑ Diabetes _____	Living or Deceased?	_____
❑ High blood pressure _____	Living or Deceased?	_____
❑ High cholesterol _____	Living or Deceased?	_____
❑ Thyroid Problem _____	Living or Deceased?	_____
❑ Epilepsy/Seizures _____	Living or Deceased?	_____
❑ Cancer (type) _____ _____	Living or Deceased?	_____
❑ Stroke _____	Living or Deceased?	_____
❑ Kidney disease _____	Living or Deceased?	_____
❑ Heart problems _____	Living or Deceased?	_____
❑ Asthma _____	Living or Deceased?	_____
❑ Anemia _____	Living or Deceased?	_____
❑ Depression/Anxiety _____	Living or Deceased?	_____
Other medical conditions (please list):		

Physician initials _____

PERSONAL/SOCIAL HISTORY

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partner/significant other

What is your current or past occupation?

Do you have an Advance Directive? ❑ Yes ❑ No

Family Drug use? ❑ Yes ❑ No Who: _____

Are there firearms present in the home? ❑ Yes ❑ No

Illicit drug use? ❑ Yes ❑ No How often: _____

Alcohol use? Frequency: _____

Tobacco Use? ❑ Yes ❑ No If yes, how much? ___ Age started? ____
E-Cigarettes ❑ Yes ❑ No If yes, how much? ___ Age started? ____

Chewing Tobacco? ❑ Yes ❑ No How much? ____ Age started? ____

Diet? ❑Regular ❑Vegetarian ❑Diabetic ❑Cardiac ❑Caffeine Exercise level? ❑Occasional ❑Moderate ❑Heavy ❑None

SURGICAL/PROCEDURE HISTORY

List surgeries: When and where:

_____
_____
_____

Procedure: When and Where:

Last Colonoscopy: When? _____ Where? _____

Last Mammogram: When? _____ Where? _____ Do you do a monthly breast exam? Y / N

PAP Smear/Cervical Screening: When? _____ Where? _____

Pregnancies: How Many? _____ Living Children? _____ Full term? _____ Pre-Term? _____
Abortion? _____ Spontaneous? ❑ Yes ❑ No Induced? ❑ Yes ❑ No

SYSTEMS REVIEW

In the past 12 months, have you had any of the following problems?

GENERAL
❑ Recent weight gain
❑ Recent weight loss
❑ Fatigue
❑ Weakness
❑ Night sweats

MUSCLE/JOINTS/BONES
❑ Numbness
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling

EARS
❑ Ringing in ears
❑ Loss of hearing

EYES
❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness

BLOOD
❑ Anemia
❑ Clots

NERVOUS SYSTEM
❑ Headaches
❑ Dizziness
❑ Fainting or loss of consciousness
❑ Memory loss

STOMACH AND INTESTINES
❑ Nausea
❑ Heartburn
❑ Stomach pain
❑ Vomiting
❑ Yellow jaundice
❑ Increasing constipation
❑ Persistent diarrhea
❑ Blood in stools
❑ Black stools

SKIN
❑ Redness
❑ Rash
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet

KIDNEY/URINE/BLADDER
❑ Frequent or painful urination
❑ Blood in urine

PSYCHIATRIC
❑ Depression
❑ Hallucinations
❑ Difficulty falling asleep
❑ Difficulty staying asleep
❑ Mood swings
❑ Anxiety
❑ Thoughts of suicide / attempts
❑ Stress

HEART AND LUNGS
❑ Chest pain
❑ Palpitations
❑ Shortness of breath
❑ Fainting
❑ Swollen legs or feet
❑ Cough

WOMEN ONLY:
❑ Abnormal Pap smear
❑ Irregular periods
❑ Bleeding between periods
❑ PMS

Physician initials _____