PATIENT REGISTRATION

Please Print Clearly and Complete All Information

neighborhood health

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Email Address	Social Security #

Address	City State	Zip	Date of Birth

Phone (Cell)	Phone (Home)

Date of Birth	What is your sex? (at birth) ☐ Male ☐ Female

To complete the form below, check the number of family members in your home in the first column and your income in the column that best describes your situation. Income is used to determine Sliding Fee discount.

☐ ***No Income reported***

FAMILY SIZE	$ 25.00 A less than or equal to:	$ 35.00 B less than or equal to:	$ 45.00 C less than or equal to:	$ 55.00 D less than or equal to:	$ 65.00 E less than or equal to:	Full Charge F Equal to or over:
☐ 1	☐ $11,880	☐ $14,850	☐ $17,820	☐ $20,849	☐ $23,768	☐ $23,769
☐ 2	☐ $16,020	☐ $20,025	☐ $24,030	☐ $28,115	☐ $32,051	☐ $32,052
☐ 3	☐ $20,160	☐ $25,200	☐ $30,240	☐ $35,381	☐ $40,334	☐ $40,335
☐ 4	☐ $24,300	☐ $30,375	☐ $36,450	☐ $42,647	☐ $48,617	☐ $48,618
☐ 5	☐ $28,440	☐ $35,550	☐ $42,660	☐ $49,912	☐ $56,900	☐ $56,901
☐ 6	☐ $32,580	☐ $40,725	☐ $48,870	☐ $57,178	☐ $65,183	☐ $65,184
☐ 7	☐ $36,730	☐ $45,913	☐ $55,095	☐ $64,461	☐ $73,486	☐ $73,487
☐ 8	☐ $40,890	☐ $51,113	☐ $61,335	☐ $71,762	☐ $81,809	☐ $81,810

INSURANCE INFORMATION / POLICY HOLDER INFORMATION

PLEASE BRING A PHYSICAL COPY OF YOUR INSURANCE CARDS	Who is the Policy Holder? ☐ Parent/Guardian ☐ Spouse ☐ Self ☐ Other _____

INSURANCE COMPANY Name

Address	City State	Zip Code

POLICY HOLDER Last Name	First Name	Middle Initial	Suffix ☐ Jr ☐ Sr ☐ Other	Gender ☐ Male ☐ Female

Date of Birth	Policy Holder Phone Number

Address	City State	Zip Code Country

Policy ID #	Group/Plan #

SECONDARY INSURANCE / OTHER INSURANCE	Who is the Policy Holder? ☐ Parent/Guardian ☐ Spouse ☐ Self ☐ Other _____

INSURANCE COMPANY Name

Address	City State	Zip Code

POLICY HOLDER Last Name	First Name	Middle Initial	Suffix ☐ Jr ☐ Sr ☐ Other	Gender ☐ Male ☐ Female

Date of Birth	Policy Holder Phone Number

Address	City State	Zip Code Country

Policy ID #	Group/Plan #

EMERGENCY CONTACT

Last Name	First Name	Relationship

Local Address	City State	Zip Code

Phone Number -- Home	Work	Cell

Patient Name	Date of Birth	*Page 2*

I give my permission for a NH representative to contact me:

Appointments	☐ Email	☐ Phone	☐ Text Message
Lab & Test Results	☐ Email	☐ Phone	☐ Text Message
Billing	☐ Email	☐ Phone	☐ Text Message
Announcements	☐ Email	☐ Phone	☐ Text Message

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.
This Release of Information will remain in effect until terminated by me in writing.

This information may be released to:

☐ Spouse ☐ Other _____
☐ Children ☐ Information is not to be released to anyone

A copy of your Medical Records is available upon written request, via printed copy or electronically.

1.) Preferred Language

☐ English ☐ French ☐ Other _____
☐ Spanish ☐ German ☐ Sign Language
☐ Arabic ☐ Italian ☐ Unreported/ Refused to Report
☐ Chinese ☐ Japanese

2.) Do you feel you have a language barrier? ☐ Yes ☐ No

3.) Race (select all that apply)

☐ Black or African American ☐ Native Hawaiian
☐ White (Caucasian) ☐ Other Pacific Islander
☐ Asian ☐ Unreported/Refused to Report
☐ American Indian or Alaska Native

4.) Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino

5.) What is your Place of Birth?

☐ United States
☐ Other, please specify:_____

6.) Housing Status

Are you homeless: ☐ Yes ☐ No

If yes: ☐ Shelter ☐ Street
☐ Doubling Up ☐ Transitional Housing

7.) Do you live in Public Housing: ☐ Yes ☐ No

8.) Agricultural Worker:

☐ Yes ☐ No

If you are an agricultural worker:
☐ Migrant ☐ Seasonal

9.) Are you a Veteran? ☐ Yes ☐ No

SIGN HERE: _____ _____

PATIENT OR RESPONSIBLE PARTY'S SIGNATURE **Date**

FOR OFFICE USE ONLY:

__Documents Reviewed __W2
__Pay Stub __Letter of Support
__Tax Statement __Etc. _____

_____ _____

NH WITNESS SIGNATURE Date

Patient Name	Date of Birth	*Page 3*

ABOUT YOU We would like you to tell us about your background so that we can review the treatment that all patients receive and make sure we provide the best possible care. Neighborhood Health maintains the privacy and security of your health information according to Federal regulations: HIPAA *(Health Insurance Portability and Accountability Act)*

Allergies

Have you ever had an allergic reaction? ☐ Yes ☐ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): _____

WHAT IS THE REASON FOR YOUR VISIT TODAY?___ _____

_____

What is your preferred Pharmacy?

Pharmacy Name: _____

Address/Location: _____

Phone #: _____

In the past two weeks how often have you been bothered by the following:

	Not at all	*Some*	*Most*	*Every Day*
a. Little Interest or pleasure in doing things (Circle)	0	1	2	3
b. Feeling down, depressed or hopeless (Circle)	0	1	2	3

Do you often feel worried, anxious, stressed or irritable? ☐ **Yes** ☐ **No**

ALCOHOL and DRUG SCREENING

Have you felt the need to cut down on drinking or drug use? ☐ **Yes** ☐ **No**

Have you ever felt annoyed by criticism of drinking or drug use? ☐ **Yes** ☐ **No**

Have you had guilty feelings about drinking or drug use? ☐ **Yes** ☐ **No**

Do you ever take a morning Eye Opener? ☐ **Yes** ☐ **No**

HEALTH SCREENING / PREVENTATIVE *(PLEASE INCLUDE THE DATE LAST PERFORMED)*

	DATE LAST PERFORMED		DATE LAST PERFORMED
ROUTINE PHYSICAL	_____	FLU SHOT	_____
MAMMOGRAM	_____	TETANUS SHOT	_____
PROSTATE SCREENING	_____	PNEUMONIA SHOT	_____
BONE DENSITY	_____	SHINGLES VACCINE	_____
CHEST X-RAY	_____	HEPATITIS VACCINE	_____
EKG	_____	OTHER VACCINES	_____
CHOLESTEROL SCREENING	_____		
DIABETES SCREENING	_____		

PAP _____ who performed your PAP: _____

COLONOSCOPY _____ who performed your colonoscopy: _____

DENTAL EXAM _____ extensive dental work? (teeth pulled, dentures, etc): _____

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Birth Family history unknown

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood clots/Clotting Disorders				
Cancer – Breast				
Cancer – Colon				
Cancer – Melanoma				
Cancer – Other Cancers (list type)				
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

What is your work history?

a. Current Occupation:

_____

Employment status:

☐ full time ☐ part time ☐ other

Do/did you have any exposure to chemicals, radiation, toxins, fumes, asbestos, blood or body fluids? *(circle all that apply)*

b. Previous Occupation:

_____

Employment status:

☐ full time ☐ part time ☐ other

Do/did you have any exposure to chemicals, radiation, toxins, fumes, asbestos, blood or body fluids? *(circle all that apply)*

c. Previous Occupation:

_____

Employment status:

☐ full time ☐ part time ☐ other

Do/did you have any exposure to chemicals, radiation, toxins, fumes, asbestos, blood or body fluids? *(circle all that apply)*

What is your current gender identity?

☐ Female ☐ Male
☐ Transgender Female-to-Male
☐ Transgender Male-to-Female
☐ Neither Exclusively Male nor Female
☐ Other _____
☐ Decline to Answer

What is your sexual orientation?

☐ Lesbian, gay
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Decline to answer

Patient Name	Date of Birth	*Page 5*

YOUR CURRENT MEDICAL HISTORY ***Check any of the following YOU have ever had or are currently experiencing.***

Heart/Lungs
- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Social History
- ☐ Do you drink alcohol?
- ☐ Do you smoke?
- ☐ Do you take recreational drugs?

Kidney
- ☐ Chronic Kidney or Bladder Disease
- ☐ Incontinence
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders *(other than glasses or contacts)*
- ☐ Hearing Loss
- ☐ Nasal Allergies/Hayfever

Infectious Diseases
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type:_____
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Other History
- ☐ Previous Hospitalizations/ER Visits

Stomach/Bowel
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Endocrine
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Mental Health
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia (Eating Disorder)
- ☐ Anxiety Disorder
- ☐ Bulimia (Eating Disorder)
- ☐ Depression
- ☐
- ☐ Other Mental Health Problems

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

Orthopedics
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Neurological
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Activity Level

Would you say your activity level is:

Example:
- ☐ Sedentary - Walk 1 hour, 2 times week or below

Example:
- ☐ Moderate - Walk 1 hour, 3 times week

Example:
- ☐ Vigorous - Walk more than 1 hour, 3 times week

STDs
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD

OB/GYN History
- ☐ Endometriosis
- ☐ Pregnancies

Last Menstrual Period

Date _____

Could you be pregnant?

☐ **Yes** ☐ **No**

Are you breastfeeding?

☐ **Yes** ☐ **No**

Surgical History
- ☐ Appendectomy
- ☐ Adenoidectomy
- ☐ Colon Surgery
- ☐ Ear Tubes
- ☐ Gallbladder Removal
- ☐ Hip Surgery L ☐ R ☐
- ☐ Knee Surgery L ☐ R ☐
- ☐ Hysterectomy
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Prostate Surgery
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries

Health Literacy

Please check your response to the questions below:

a. How often do you have someone help you read medical materials?

1 ☐ Always 2 ☐ Often 3 ☐ Sometimes 4 ☐ Occasionally 5 ☐ Never

b. How often do you have a problem understanding the written materials about your medical condition?

1 ☐ Always 2 ☐ Often 3 ☐ Sometimes 4 ☐ Occasionally 5 ☐ Never

c. How often do you have a problem understanding what is told to you about your medical condition?

1 ☐ Always 2 ☐ Often 3 ☐ Sometimes 4 ☐ Occasionally 5 ☐ Never

d. How confident are you filliing out medical forms by yourself?

1 ☐ Not at all 2 ☐ A little bit 3 ☐ Somewhat 4 ☐ Quite a bit 5 ☐ Extremely

Do you have any disabilities or impairments?
- ☐ No
- ☐ Yes, *please specify*

Be prepared to inform the nurse, and any other providers, of current medications (include birth control, acne, over the counter medications, vitamins, etc.)

Choose ONE of the activities below that you would like to improve upon:
- ☐ Stay more physically active
- ☐ Take my medications
- ☐ Improve my food choices
- ☐ Reduce my stress
- ☐ Cut down on smoking