PATIENT MEDICAL HISTORY/ HISTORIA MEDICA DEL PACIENTE

(**PLEASE PRINT**/ POR FAVOR, ESCRIBA CON LETRA DE IMPRENTA)

Date / Fecha _____ **Home Phone** / Teléfono de Casa (_____) _____

Patient / Paciente _____

Last Name / Apellido First Name / Primer Nombre Middle Initial / Segundo Nombre Preferred Name / Nombre Preferido

Street Address / Dirección _____ **City /** Ciudad _____

State / Estado _____ **Zip /** Código Postal_____ **Cell Phone /** Teléfono celular (_____) _____

Birthdate / Fecha de Nacimiento _____ **Age** / Edad_____ **Sex** / Sexo ☐M ☐F

Social Security Number / Numero de Seguro Social _____

In Case of emergency, who should be notified? / ¿En caso de emergencia, quién debe ser notificado? _____

Phone / Teléfono (_____) _____

Whom may we thank for referring you? / ¿A quién le podemos dar las gracias por haberlo referido? _____

MEDICAL HISTORY / HISTORIA MEDICA

Physician's Name / Nombre de su Medico _____ **Date of Last Physical** / Fecha del último Examen Físico _____

Have you ever had any of the following? (check boxes that apply) / ¿Ha tenido usted cualquiera de los siguientes? (marque los cuadros que le correspondan):

☐**Allergies**/Alergias
☐**Arthritis**/Artritis
☐**Artificial Heart Valves**/Válvulas Artificiales de Corazón
☐**Asthma**/Asma
☐**Back Problems**/Problemas de la Espalda
☐**Bleeding Abnormally**/Sangrado Irregular
☐**Blood Disease**/Enfermedad de la Sangre
☐**Cancer**/Cáncer
☐**Chemical Dependency**/Dependencia Química
☐**Chronic Diarrhea**/Diarrea Crónica
☐**Circulatory Problems**/Problemas Circulatorios
☐**Congenital Heart Lesions**/Lesiones Congénitas de Corazón
☐**Diabetes**/ Diabetes
☐**Headaches**/Dolores de Cabeza
☐**Heart Murmur**/Soplo en el Corazón
☐**Heart Problems**/Problemas del Corazón
☐**Hemophilia**/Hemofilia
☐**Hepatitis**/Hepatitis
☐**High Blood Pressure**/Presion alta de Sangre
☐**HIV/AIDS** VIH/SIDA
☐**Joint Replacement**/Reemplazo Conjunto
☐**Kidney Problems**/Problemas del Riñón
☐**Liver Problems**/Problemas del Hígado
☐**Low Blood Pressure**/Presion baja de Sangre
☐**Mitral Valve Prolapse**/Prolapso Mitral de Válvula
☐**Nervous Problems**/Problemas Nerviosos
☐**Osteoporosis**/Osteoporosis
☐**Pacemaker**/Marcapasos
☐**Psychiatric Care**/Cuidado Psiquiátrico
☐**Radiation Treatment**/Tratamiento de Radiación
☐**Recent Weight Loss**/Pérdida de Peso reciente
☐**Respiratory Disease**/Enfermedad Respiratoria
☐**Rheumatic Fever**/Fiebre Reumática
☐**Seizure**/Epilepsia
☐**Sinus Problem**/Problema de Sinusitis
☐**Special Diet**/Dieta especial
☐**Stroke**/Embolia Cerebral
☐**Swollen Neck Glands**/Glándulas del Cuello Hinchadas
☐**Thyroid**/Tiroides ☐**Hyper**/Alto ☐**Hypo**/Bajo
☐**Ulcer**/ Ulcera
☐**Venereal Disease**/Enfermedad Venérea

When was your last dental visit? / ¿Cuándo fue su última visita al dentista? _____ **For what procedure?** ¿Para qué procedimiento? _____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ¿Tiene alergias a alguna droga o ha tenido usted una reacción adversa a cualquier medicina o anestesia? ☐ **Yes/Sí** ☐ **No**

If so, what? / Si la respuesta es afirmativa, ¿a qué? _____

Have you ever responded adversely to medical or dental treatment? / ¿Ha reaccionado usted adversamente a un tratamiento médico o dental?

_____

Please list any medication you are taking at this time. / Por favor liste cualquier medicamento que usted esté tomando en este momento.

_____

Have you ever taken any of the groups collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) / ¿Alguna vez ha usted tomado cualquiera de los grupos segun referidos colectivamente como el "fenfen"? Esto incluye combinaciones de Ionimin, Adipex, Fastin (nombres de marca de fentermina), Pondimin (fenfluramina) y Redux (dexfenfluramina) ☐ **Yes/Sí** ☐ **No**

Have you ever taken pills or received shots that are bone density drugs/ Bisphosphonates? Some examples are Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, Zometa. ¿Ha tomado usted pastillas o ha recibido inyecciones de drogas que son para la densidad de hueso? Por ejemplo Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, Zometa. ☐ **Yes/Sí** ☐ **No**

Are you under the care of a physician? / ¿Está bajo el cuidado de algún doctor? ☐ **Yes/Sí** ☐ **No**

For what conditions? / ¿Para qué tipo de condición médica? _____

(Women) Do you suspect that you are pregnant? / (Mujeres) ¿Sospecha que usted está embarazada? ☐ **Yes/Sí** ☐ **No**

Due date / Fecha de parto _____ **Are you nursing?** / ¿Esta usted dando pecho? ☐ **Yes/Sí** ☐ **No**

Taking birth control pills? / ¿Está tomando píldoras anticonceptivas? ☐ **Yes/Sí** ☐ **No**

Heart City Health

Patient Registration

Date _____ Email address _____

Name _____ Date of Birth _____

Sex _____ Age _____ Social Security Number _____

Address _____

City _____ State _____ Zip Code _____ Phone Number _____

US Citizen? _____ Are you a student? _____ Race _____ Marital Status _____

Occupation _____ Primary language _____ Referred by _____

If patient is under 18, who is responsible for the account? _____

Relationship with Patient _____

List all people in your house, their age and relationship to you:

Name	Age	Relationship	Medicaid?	Working?

Monthly Household Income (Circle the most accurate answer)

☐ $0-$600 ☐ $600-$1200 ☐ $1201-$1800 ☐ $1801-$2400 ☐ $2401-$3000 ☐ $3000+

Employer _____ Phone Number _____

School _____ Phone Number _____

In case of emergency, please contact _____ Phone Number _____

How did you hear about us? ☐ Billboard ☐ Center for Healing & Hope ☐ Faith Mission

☐ Health Coalitions ☐ Radio ☐ TV ☐ Website ☐ Word of Mouth ☐ Other _____

Heart City Health

UDS Demographic Data Collection

As a Federally Qualified Health Center (FQHC) receiving federal funding, Heart City Health Center is required to gather information from patients that can be reported back to the federal government annually, enabling us to continue to pass along affordable healthcare options in Elkhart. We kindly ask you to take a moment to answer the following questions.

ESTIMATED MONTHLY HOUSEHOLD INCOME (Circle the most accurate estimate)

☐ $0-$600 ☐ $600-$1,200 ☐ $1,201-$1,800 ☐ $1,801-$2,400 ☐ $2,401-$3,000 ☐ $3,001+

FAMILY SIZE: _____

SOCIAL DEMOGRAPHICS: (Please check the box next to most accurate response)

Gender Identity		Sexual Orientation	
Male	☐	Lesbian, gay or homosexual	☐
Female	☐	Straight or heterosexual	☐
Transgender Male (Female-to-Male)	☐	Bisexual	☐
Transgender Female (Male-to-Female)	☐	Something else	☐
Gender queer	☐	Don't Know	☐
Other	☐	Choose not to disclose	☐
Choose not to disclose	☐		
Miscellaneous			
Agricultural	☐		
Homeless	☐		
Military Veteran	☐		

Thank you for taking the time to provide this information for federal reporting purposes.

_____ Patient's Name

_____ Date of Birth

_____ Responsible Person or Legal Guardian's Name

_____ Relationship with Patient

_____ Date

Heart City Health

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Parent or Guardian Date

_____ _____

Please print patient's name, Parent or Guardian Relationship to patient

Notice of Privacy Practice Acknowledgement

By signing below, I acknowledge that I have received a written copy of Heart City Health Center's, Inc. Notice of Privacy Practices and Rights and Responsibilities.

_____ _____

Patient's Name Date

_____ _____

DOB Patient's Signature

_____

Responsible Person or Legal Guardian's Name

Heart City Health

Consent to Treat

I understand that I require treatment in this facility because of my condition. I permit my provider (s), students in training, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, nursing care, and examinations, medical and surgical treatment. I recognize it is the responsibility of my provider to explain to me the nature of any diagnostic test, medical, surgical procedures and/or immunizations judged by him/her as necessary for my treatment and to advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my physician as to the result of any treatments, examinations, and/or operative procedure performed at Heart City Health Center, Inc.

_____ _____

Patient's Name DOB Responsible Person or Legal Guardian's Name

_____ _____

Date Printed Name & Relationship of Person Above

Please read and initial the following

1. I give permission for confidential information to be left on my answering machine. _____
2. I give permission for mail to be sent to my home address regarding test results. _____
3. I hereby authorize the provider involved with my care to release information from my medical record as may be required to any person, corporation, or agency which is legally responsible. ____
4. I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. _____
5. I hereby assign payment directly to Heart City Health Center, Inc. _____
6. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payers. _____

Heart City Health

Medical Treatment Authorization and Consent Form of a Minor

The following form is designed for those situations where minors are unaccompanied by either parent or legal guardians. This "Medical Treatment Authorization and Consent Form of a Minor" gives authority to a designated adult to arrange for medical care for a minor in the absence of the parent/legal guardian.

I _____ being the parent/legal guardian of _____
Parent or Legal Guardian Patient's Name
hereby authorize the following individual/s to give informed consent to any and all medical, dental care, treatment and/or attention for my child/ward which is deemed necessary and appropriate by a Heart City Health Center, Inc. provider in my absence.

Name	Relationship to Patient	DOB
Name	Relationship to Patient	DOB
Name	Relationship to Patient	DOB

Initial the box next to your choice.

This authorization:

☐ **Expires** on:___/ ___/20___ upon which I will sign a new authorization.

or

☐ Is **Open-Ended** (I understand that I have to notify Heart City Health Center, Inc. if I decide to revoke this authorization and that Heart City Health Center, Inc. will accept my decision to revoke).

I understand that I can revoke this authorization at any time by communicating this in writing or verbally to Heart City Health Center, Inc. staff.

X _____ _____
Signature of Parent or Legal Guardian Date

I declare that I witnessed the signing of this document by the parent or the legal guardian on the date noted above.

_____ _____
HCHC Staff Signature Printed Name

Heart City Health

Permission to Disclose Confidential Protected Health Information

_____ _____

Patient's Name DOB

I give my permission for my health information to be released to the following:

_____

Name Relationship DOB

_____

Name Relationship DOB

_____

Name Relationship DOB

_____ _____

Patient's Signature Date

Heart City Health

Advanced Directives Acknowledgement Form

Heart City Health Center, Inc. recognizes the rights of all adult individuals with decision making capacity to participate in decision making concerning their health care and medical treatment. Advanced Directives shall be followed by Heart City Health Center, Inc. to the extent permitted and required by Indiana Law.

Heart City Health Center, Inc. respects the right of individual choice in executing or not executing Advanced Directives for health care and medical treatment. We do not condition the provision of medical care or discriminate against an individual based on whether or not an Advanced Directive has been executed.

Heart City Health Center, Inc. is committed to the education of our own employees, as well as the community, regarding their rights to formulate Advanced Directives and the right of individuals to consent to or refuse medical treatment.

For the purpose of this policy, "Advanced Directives" means a written instruction such as a Living Will Declaration, Life Prolonging Procedure Declaration, and Appointment of Health Care Representative, or Power of Attorney for health care purposes. These Advance Directives are established under Indiana Law and relate to the provision of medical care when an individual is incapacitated.

If you have an Advanced Directive, Living Will Declaration, or Life Prolonging Procedure Declaration, Heart City Health Center, Inc. will ask you to provide a copy to store in your current health record.

Date _____

Yes, I have an advanced directive _____
Signature

No, I do not have an advanced directive _____
Signature

INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday *(mm/dd/yyyy)*	Medical Record Number of Healthcare Facility or Provider *(optional)*	Healthcare Facility or Provider *(optional)*

Appointment of Health Care Representative

I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

I specify the following terms and conditions *(if any)*:

Name of Representative Appointed	Address of Representative *(number and street, city, state, and ZIP code)*	Telephone Number of Representative
Signature of Patient / Appointor or Designee *(must be signed in the appointor's presence)*	Printed Name of Patient / Appointor or Designee	Date of Appointment *(mm/dd/yyyy)*
Signature of Witness	Printed Name of Witness	Date *(mm/dd/yyyy)*

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.

2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.

3. An individual is not required to complete a health care representative appointment form. An individual may always chose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.

4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.

5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

6. The authority granted becomes effective according to the terms of the appointment.

7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.

8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.

9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.

10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
    a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
    b. In good faith.

11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
    a. The patient / appointor.
    b. The patient's / appointor's legal representative if one is known.
    c. The health care provider if the representative knows there is one.

12. An individual who is capable of consenting to health care may revoke:
    a. The appointment at any time by notifying the representative orally or in writing; or
    b. The authority granted to the representative by notifying the health care provider orally or in writing.

Heart City Health

Rights and Responsibilities

Staff members at Heart City Health Center, Inc. are dedicated to providing you with the best possible care and treatment. As a participant in your health care, your Rights and Responsibilities at Heart City Health Center, Inc. are:

Rights:

1. **You will be treated with courtesy.**
2. **You are entitled to information concerning your diagnosis, treatment, and prognosis.**
3. **You have the right to participate in making decisions regarding your health care.**
4. **You have the right to know the names of the people caring for you and their role in your treatment.**
5. **You may look at or obtain copies of your medical records. A fee will be charged for copies.**
6. **You may expect privacy and safe surroundings while you are at the center.**
7. **You may expect that information and records about your care will be kept confidential.**
8. **You will be notified in advance whenever possible, when your provider cannot keep an appointment.**
9. **You may ask questions if you are dissatisfied with your care.**
10. **You will not be discriminated against because of your race, religion, color, national origin, gender, age, political beliefs, handicaps, marital status, sexual preference, or source of payment.**
11. **You have a right to the best possible care. You will not be deprived of any benefits, rights or privileges guaranteed by federal or state law.**

Responsibilities:

1. **You are expected to observe Heart City Health Center, Inc. rules.**
2. **You must have an appointment to see a provider.**
3. **If you cannot keep a scheduled appointment, it is your responsibility to call and cancel before your scheduled appointment time. If you have three (3) missed appointments in a calendar year, you will be placed on a 6-month walk-in basis from your last No-Show Appointment.**
4. **Tell your provider as accurately as you can all about your past illnesses and your present condition, including hospital stays, seen another doctor in the past, taking medications, bring a list of medications with dosages.**
5. **If your condition changes, or if you have a problem with your treatment, tell your provider immediately.**
6. **If you do not understand your treatment, or what is expected of you, tell your provider immediately.**
7. **Follow the advice and instructions your provider gives you about your care.**
8. **If you refuse treatment or do not follow instructions, you may be denied further care at the center.**
9. **The charge for your treatment is your responsibility. Payment for services is requested at the time of your appointment. You will be billed for any balance owed.**

Heart City Health

By Signing below I acknowledge that all information within the New Patient Packet is correct, current and accurately stated to the best of my knowledge.

_____ _____

Patient's Name Patient's Signature

_____

Date

_____ _____

HCHC Staff Date