

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):

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

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

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



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