NEW PATIENT REGISTRATION FORM

General Information (Please Print)

First Name	Last Name	Middle Initial

Social Security Number	Date of Birth (Month/Day/Year)	Please Indicate your Sexual Orientation
		☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Don't Know ☐ Something Else ☐ Choose not to Disclose

Please indicate the gender you most closely identify with

☐ Male ☐ Female ☐ Transgender Female (Male to Female) ☐ Transgender Male (Female to Male) ☐ Other ☐ Choose not to Disclose

Address	Apt.

City	State	Zip Code

Race (Please Check all that Apply)	Ethnicity
☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other Pacific Islander ☐ Native Hawaiian	☐ Hispanic ☐ Not Hispanic

Preferred Language	Relationship Status	Education Level (Highest Grade Completed)
☐ English ☐ Spanish	☐ Single ☐ In a Relationship ☐ Married ☐ Divorced	☐ 8th grade or less ☐ 9th ☐ 10th ☐ 11th ☐ 12th

How did you hear about Community Health Connection?

☐ Family/Friend ☐ Health Fair/Event/Outreach ☐ Newspaper/Magazine/Pamphlet ☐ Radio ☐ TV ☐ Website/Social Media ☐ Other Advertising ☐ Referral from another Provider

Patient Communication – MUST BE COMPLETED

Please tell us your preferred method of contact. We will do our best to protect your privacy and confidentiality. ***NOTE:*** *We are required by law to contact you if you have any abnormal test results. This may require us to break confidentiality if we cannot reach you through your preferred method of contact.*

Preferred Contact Method	How shall we identify ourselves?
☐ Cell Phone ☐ Alternate Phone ☐ Mail ☐ CHC Portal (must provide a valid email	☐ Community Health Connection ☐ Doctor's Office ☐ A Friend

Cell Phone Number	Alternate Phone Number	Email Address

Can we mail letters to your home address listed above?	If no, where can we mail any abnormal test results?

Emergency Contact Name	**Emergency Contact Phone Number**	**Emergency Contact Relationship**

Payment Information

Our goal is to make sure you receive excellent and affordable health care. In order to keep our fees low for all patients, we require payment at the time of service. You may provide payment by:

- ***Private Insurance –*** *Providing us with private insurance information. This may require a copay to be paid at time of service. You must have your insurance card with you so we can bill your insurance.* ***Note:*** *Your insurance provider will likely send a notice of payment to the primary member.*
- ***Medicaid –*** *Medicaid will cover the cost of your appointment if you qualify.* ***Note:*** *Since Community Health Connection, Inc. (CHC) is not a Title X clinic, you may receive some mail from SoonerCare regarding your appointment today.*
- ***Pay Out-of-Pocket –*** *If you choose to pay out-of-pocket for services, full payment must be rendered at time of service. We accept cash, check, and debit/credit cards.*

How are you paying for today's visit? (Check all that Apply)

☐ Private Insurance ☐ Medicaid ☐ Out-of-Pocket

Insurance Information (Please fill out if you are paying with private insurance and/or Medicaid)

Insurance Company Name/Medicaid	Address

City	State	Zip Code	Phone Number

Effective/Issue Date	Group Number	Member Number/Claim Number	Patient's Relationship to Subscriber

Subscriber's Name	Subscriber's Employer

PATIENT INFORMATION

Name (Last, First, Middle)	Date of Birth	Social Security Number	Visit Date

Break Out History

What is the reason for your visit today?

Are you allergic to any medications, metals, latex, rubber gloves, tape, shellfish or antiseptic solutions? ☐ Yes ☐ No	If yes, please list your allergies:

List any medications you are taking, including over-the-counter vitamins, supplements and/or herbal medications:

PAST MEDICAL HISTORY

General Information (Please Print)

Please indicate if you have ever had any of the following (check all that apply):

- ☐ Heart Disease or Heart Attack
- ☐ Heart Valve Problem
- ☐ Blood Clot(s) in Veins or Lungs
- ☐ Stroke
- ☐ Seizures or Epilepsy
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Anemia (low iron)
- ☐ Gall Bladder Removal
- ☐ Liver Problems
- ☐ Asthma, breathing problems, or other lung disease
  - Do you use an inhaler? ☐ Yes ☐ No
- ☐ Kidney Disease or Kidney Failure
- ☐ Bowel Disease (e.g. IBS, Crohn's)
- ☐ Rectal or Bladder Surgery
- ☐ Thyroid Disease
- ☐ Cushing's Syndrome
- ☐ Long-term Steroid Medication Use
- ☐ Cancer
- ☐ Migraines
- ☐ Lupus
- ☐ Severe Long-term Depression
- ☐ Diabetes
  - Do you use insulin? ☐ Yes ☐ No
- ☐ Herpes
- ☐ Chlamydia or Gonorrhea
- ☐ Pelvic Inflammatory Disease
- ☐ Hydrocele (enlarged testicle)
- ☐ Varicocele (enlarged veins in scrotum)
- ☐ Hernia
- ☐ Uterine Abnormalities/Fibroids
- ☐ Ovarian Cysts
- ☐ Genital Warts

Have you had any serious illnesses, hospitalizations, surgeries or blood transfusions? Please explain:

Social History (Do you currently use, or have you ever used, any of the following)

Tobacco ☐ YES ☐ NO	Packs or Cans per Day	For How Many Years	Date Quit	Other Nicotine (Vapor inhalers, e-cigarettes) ☐ YES ☐ NO

Alcoholic Beverages ☐ YES ☐ NO	Frequency (once a day, once a month, etc.)	Amount (2 drinks, 6-pack, etc.)

Caffeinated Beverages ☐ YES ☐ NO	Type	Amount of Caffeine per Day

Use street or IV drugs or abuse prescription drugs or other substances. ☐ YES ☐ NO	What type and how often used?

Have/Had a partner who uses/used street or IV drugs ☐ YES ☐ NO	What type and how often used?

Sexual History

Have you ever had sex? ☐ YES ☐ NO	Are you currently sexually active? ☐ YES ☐ NO	Is/Are your partner(s)? ☐ Male ☐ Female ☐ Transgender	What type(s) of sexual contact have you had? ☐ Vaginal ☐ Anal ☐ Oral

How many sexual partners have you had in the past year?	How many sexual partners have you had in the past 60 days?	Does your partner have other partners? ☐ YES ☐ NO ☐ Not Sure

Do you use condoms? ☐ YES ☐ NO	How often do you use condoms? ☐ Never ☐ Sometimes ☐ Almost Always ☐ Always

PATIENT INFORMATION

Name (Last, First, Middle)	Date of Birth	Social Security Number	Visit Date

Menstrual/Contraceptive History

When was the first day of your last menstrual period?	Was your last period normal? ☐ YES ☐ NO	If no, please explain:
Do you have problems with your period? ☐ YES ☐ NO	If yes, please explain:	
Have you ***ever*** used birth control? ☐ YES ☐ NO	If yes, what kind of birth control have you used?	
Do you ***currently*** use birth control? ☐ YES ☐ NO	If yes, what kind of birth control are you currently using?	
Have you ever had any problems with the birth control you currently use or any birth control you used in the past? ☐ YES ☐ NO	If yes, please explain:	

Pregnancy History

Are you currently pregnant? ☐ YES ☐ NO	Number of pregnancies:	Number of Vaginal Deliveries:	Number of C-Sections:	Number of Miscarriages:	Number of Abortions:	Number of Ectopic (tubal) pregnancies:
When did your last pregnancy end?	Are you currently breastfeeding? ☐ YES ☐ NO	Any breastfeeding complications?				
Have you had complications from any other pregnancies? Please explain:						
If you were to find out you were pregnant today, how would you feel? ☐ Extremely happy/excited ☐ Somewhat happy/excited ☐ Neither happy/excited or upset/worried ☐ Somewhat upset/worried ☐ Extremely upset/worried						

CONSENT FOR MEDICAL CARE

Community Health Connection, Inc. (CHC) personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

I understand and agree that I am ultimately responsible for the balance on my account for any professional service(s) rendered. I have completed the above questions on page 1,2 & 3 of this packet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information. I request that payment of authorized medical benefits, if any, be made to Community Health Connection, Inc. (CHC) on my behalf for any unpaid service(s) rendered by Community Health Connection (CHC).

I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or non communicable disease, mental health, and substance or alcohol abuse.

Signature of Patient _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Community Health Connection, Inc.'s (CHC's) Notice of Privacy Practices and I consent to the use of my protected health information (PHI) for treatment, payment, and healthcare operations CHC has summarized in the Notice.

I understand that I may refuse to sign this acknowledgement.

Patient/Authorized Representative* (Please Print) _____ Relationship to Patient _____

Patient/Authorized Representative* (Signature) _____ Date _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:
☐ Individual refused to sign. ☐ Communication barriers prevented signature of acknowledgement. ☐ An emergency situation prevented signature of acknowledgement.
☐ Other: _____