NEW PATIENT REGISTRATION FORM											
General Information (Please Print)											
First Name			Last Name	Last Name				Middle Initial			
Social Security Number	Date of Birth	(Month/Day/Y	ear)		se indicate your Sexua						
Please indicate the gender you most closely	identify with			O Le	esbian/Gay O Straig	ething Else	O Choose Not to Disclose				
	•	emale) O Ti	ansgender Male	e (Female :	to Male) Other	○ Choose N	ot to Disclose				
Address	iale (iviale to i	emale) O m	ansgender war	ender Male (Female to Male) O Other O Choose Not to Disclose					Apt.		
City						State	Zip Code				
Race (Please Check all that Apply)								Ethnicity			
O American Indian/Alaska Native O Asia	n O Black	or African Ame	rican O Whit	e O Oth	ner Pacific Islander	O Native Haw	vaiian	O Hispanio	c O Not Hispanic		
Preferred Language		Relationsh	ip Status				Education Level (Highest Gra	lucation Level (Highest Grade Completed)			
O English O Spanish How did you hear about Community Health	Cannatian	O Single	O In a Relation	onship O	Married O Divorce	d	O 8th Grade or less O 9th	or less O 9th O 10th O 11th O 12th			
,				0.71/	0.14.1.11.10.1.114						
O Family/Friend O Health Fair/Event/Out	reach O Ne	wspaper/Maga	izine O Radio	OIV	O Website/Social M	edia O Oth	er Advertising O Referral from	m another Pro	ovider		
Patient Communication – MU	IST BE CO	OMPLETE	D								
Please tell us your preferred methologies any abnormal test results. The											
Preferred Contact Method	<u> </u>				How do we identify ou	rselves?	<u> </u>				
O Cell Phone O Alternate Phone O Ma	ail O CHC P	ortal (Must pro	vide a valid ema	ail)	O Community Health	Connection	O Doctor's Office O A Frie	nd			
Cell Phone Number		Alternate Ph	one Number		Email Address						
Can we mail results to you home address lis	ted above?	If No, w	nere can we ma	il any abno	ormal test results						
Emergency Contact Name			Emergency Contact Phone Number Emer			Emergency Contact Relation	ship				
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 so we can bill your insurance. No 								t have you	r insurance card with you		
• Medicaid – Medicaid will cover th					ionoo or r aymone	to the phin	ary mombon.				
• Pay Out-of-Pocket – If you choo	•			•	ent must be rende	ered at time	of service. We accept ca	ish, check,	and debit/credit cards.		
How are you paying for today's visit?		,		. ,			,				
O Private Insurance O Medicaid O Ou	t-of-Pocket										
Insurance Information (Please fill out if your paying with Private Insurance or Medicaid)											
Insurance Company Name/Medicaid Address											
City			Z	Zip Code		Phone Nu	umber				
Effective/Issue Date Group Number Mei				Membe	ember Number/Claim Number Patients Relationship to Subscriber						
Subscriber's Name					Subscriber's Employer						



DATIENT HIGTORY									
PATIENT HISTORY									
Name (Last, First, Middle)			Date of Birth		Social Security Number	Visit Date			
5									
Break Out History									
What is the reason for your visit tod	day?								
Are you allergic to any medications, metals, latex, rubber gloves, tape, shellfish or antiseptic solutions? If Yes, please list your allergies:									
tape, shellfish or antiseptic solutions Yes O No	is?	ber gioves,	ir res, piease list your allergies.						
List any medications you are taking	g, including over-the	e-counter vitamins,	supplements and/or herbal medicati	ions:					
PAST MEDICAL HISTOI	RY								
General Information (Pl		_		_					
Please indicate if you have eve		following	Asthma, breathing problems, or o	nthar lung disass	se O Diabetes				
(check all that apply):	er nad any or the	Tollowing	Do you use an inhaler? O Yes (insulin? ○ Yes ○ No			
O Heart Disease or Heart Attack	K		Kidney Disease or Kidney Failur		O Herpes	•			
O Heart Valve Problem			Bowel Disease (e.g. IBS, Crohn'	s)	O Chlamydia o				
O Blood Clot(s) in Veins or Lung	gs		Rectal or Bladder Surgery	ammatory Disease					
O Stroke			O Thyroid Disease	(enlarged testicle)					
O Seizures or Epilepsy			Cushing's Syndrome	(enlarged veins in scrotum)					
O High Blood Pressure			D Long-term Steroid Medication Us	O Hernia					
O High Cholesterol			O Cancer			Abnormalities/Fibroids			
O Anemia (low iron)			O Migraines		O Ovarian Cys				
O Gall Bladder Removal			D Lupus	rts					
O Liver Problems			Severe Long-term Depression						
Have you had any serious illnesses	s, hospitalizations,	surgeries or blood	transfusions? Please explain:						
Social History (Do you	currently us	e, or have y	ou ever used, any of the	following)					
Tobacco F	Packs/Cans per day	У	For How Many Years Date Quit			Other Nicotine (Vapor inhalers, e-cigarettes)			
O Yes O No						O Yes O No			
Alcoholic Beverages F	Frequency (once a day, once a		Amount (2 drinks, 6-pack, etc.)			1			
n	month, etc.)								
O Yes O No Caffeniated Beverages T	Туре		Amount of Caffeine per Day						
O Yes O No									
	poorintion drives	What type and h	low often used?						
Use street or IV drugs or abuse prescription drugs or other substances. O Yes O No			TION ORDIT USGG:						
drugs.			d how often used?						
O Yes O No									

Sexual History									
Have you ever had sex?	Are you currently sexually	active?	Is/Are your partner(s):	What type(s) of sexual contact have you had?					
O Yes O No	O Yes O No		O Male O Female O Transgender	O Vaginal O Anal O Oral					
How many sexual partners have you had in the past year?		How many sexual p	partners have you had in the past 60 days?	Does your partner have other partners?					
				○ Yes ○ No ○ Not Sure					
Do you use condoms?		How often do you use condoms							
O Never O Sometimes O Almost Always O Always									



Name (Last, First, Middle) Date of Sinh Social Security Number of Name Park	PATIENT HISTORY											
When vas the first day of your last manufactural period? When you serv used before with your proted? If Yes, yellows a seption: O'Yes O No The you currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No The your currently use brith control? O'Yes O No O'Yes O No The your currently used the period. O'Yes O No O'Yes O	Name (Last, First, Middle)			C	ate of Birth	of Birth Social Security Number			Visit Date			
When was the first day of your last manufaul period? Weap One												
When was the first day of your last manufaul period? Weap One	Menstrual/Contraceptive History											
Doyse In were to find out you were prepared. When deep representative for the proposed of the				Was your last pe	eriod Normal?	If No, please explain:						
O'tis O No If Yos, what kind of birth control have you use? O'tis O No Doyoe currently use birth control? If Yos, what kind of birth control have you use? O'tis O No Doyoe currently use birth control? If Yos, what kind of birth control have you use? O'tis O No O'tis				O Yes O No								
If Yes, what kind of brith control? If Yes, what kind of brith control have you used?	Do you have problems with yo	our period?	If Yes, please	e explain:								
O'tes O No De you currently use birth control? If Yes, what kind of birth control have are you using? Ver O No Pregnancy History Are you currently out set for pregnancies: Number of Pregnancy History Are you currently pregnant? Number of Pregnances: Number of Pregnances: Number of Vegnances: Number of Vegnances: Number of Sections: Number of Abortions Number of Abortions Number of Ectopic (bubal) pregnancies: Number of Local pregnances: Number of Local pregnanc												
Do you currently use bith contro? If Yes, what kind of bith control have are you using? Pregnancy History Are you currently pregnant? Number of Negarances:	Have you ever used birth con	n control? If Yes, what kind of birth control have you used?										
O'Ne O No Here you were that any problems with the birth control you currently left Yes, please explain: □ Ne O No Pregnancy History Are you currently pregnant? Number of Pregnancies: Number of Veginal Deliveries: Number of C-Sections: Number of Miscarriages: Number of Abortions Number of Ectopic (tubal) pregnancies: Number of Pregnancies: O'Ne O No When old your lest pregnancy end? Are you currently breastfeeding? Any breastfeeding complications? ○ Yes O No Here you had complications from any other pregnancies? Please explain: If you were to find out you were pregnant today, how would you feel? ○ Extremely happylexicited O Somewhat happylexicited O Neither happylexicited of upset/worried O Somewhat upset/worried O 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. Inhere the right to consent or rebuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances. I understand and agree that I am utilinately responsible for the balance on my account for any professional sendec(s) rendered. I have completed the above questions on page 1.2 3 of this packet and certify this information is to the end connect to the best of my knowledge, livil notify you of any otherings in my insurances status or any of the above questions on page 1.2 3 of this packet and certify this information to the health plan indicated for information requested by the health Connection (CHC). I Lauthorize the release of medical information about communicable or information requested by the health, and substance or alcohol abuse. Signature of Patient Date Patient/Authorized Representative* (Please Print) Relationship to Patient Patient/Authorized Representative* (Signature) Patient/Authorized Representative* (Signature) Patient/Authorized Representative* (Signature) Patient/Authorized Representative* (Sig												
Here you were that any problems with the birth control you currently accurrently accurrently according to the past? Pregnancy History Are you currently pregnant? Number of Pegnances: Number of Abortions: Number of A												
Pregnancy History Are you currently pregnant? Number of Pregnancies: Number of Visignal Deliveries: Number of C-Sections: Number of Miscarriages: Number of Abortions Number of Estopic (tubul) pregnancies: O'Yes O No Number of Use of No Use of Number of Use of N		ems with the bi	rth control you	u currently If	Yes, please exp	plain:						
Are you currently pregnant? Number of Pregnancies: Number of Vaginal Deliveries: Number of C-Sections: Number of Miscarriages: Number of Abortions Number of Ectopic (tubel) pregnancies: When did your last pregnancy end? Are you currently breastfeeding? Are you currently breastfeeding? Are you be completed to the pregnancy end? Are you currently breastfeeding? Are you be completed to the your last pregnancy end? Are you currently breastfeeding? Are you be completed to the your last pregnancy end? Are you currently breastfeeding? Are you carrently breastfeeding? Are you carrently breastfeeding? Are you currently breastfeeding? Are you carrently breastfeeding? Are you west of ind out you were pregnant today, how would you feel? Are you west of ind out you were pregnant today, how would you feel? Are you west of ind out you were pregnant today, how would you feel? Are you west of ind out you were pregnant today, how would you feel? Are you west of ind out you were pregnant today, how would you feel? Are you west of ind out you were pregnant today, how would you f	use or any birth control you used in the past?											
O'res O No When did your last pregnancy end? Are you currently breastleading? Any breastleading complications?	Pregnancy History											
O'Yes O No When did your last pregnancy end? Are you currently breastfeeding? Ary breastfeeding complications? Flyou were to find out you were pregnant today, how would you feel? O Extremely happy/excited O Somewhat happy/excited O Neither happy/excited or upset/worried O Somewhat 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 belance on my account for any professional service(s) rendered 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. 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 ma	Are you currently pregnant?	Number of P	regnancies:	Number of V	/aginal Deliveri	es: Number of C-Sec	tions: N	lumber of Miscarriages:	Number of Aborti	ons	,	
Have you had complications from any other pregnancies? Please explain: If you were to find out you were pregnant today, how would you feel? O Extremely happy/excited O Somewhat happy/excited O Neither happy/excited or upset/worried O Somewhat upset/worried O 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 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 No											pregnancies:	
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Patient/Authorized Representative* (Signature) Date FOR OFFICE USE ONLY				J								
FOR OFFICE USE ONLY	Patient/Authorized Representative* (Please Print) Relationship to Patient								ship to Patient			
	Patient/Authorized Representative* (Signature) Date								Date			
					, F	OR OFFICE USE	ONLY					
O Individual refused to sign — O An emergency situation prevented signature of acknowledgement — O Communication barriers prevented signature of acknowledgement	'		•		ur Notice of F	Privacy Practices, but	acknowled	•				



O Other:_

*May be required to show proof of Representative Status