

**NEW PATIENT REGISTRATION FORM****General Information (Please Print)**

First Name		Last Name		Middle Initial
Social Security Number		Date of Birth (Month/Day/Year)		Gender Assigned at Birth <input type="radio"/> Male <input type="radio"/> Female
Please indicate the gender you most closely identify with <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Transgender Man/Transgender Male/Transmasculine <input type="radio"/> Transgender Woman/Transgender Female/Transfeminine <input type="radio"/> Other <input type="radio"/> Declined to Specify			Please Indicate your Sexual Orientation <input type="radio"/> Lesbian/Gay <input type="radio"/> Straight <input type="radio"/> Bisexual <input type="radio"/> Don't Know <input type="radio"/> Something Else <input type="radio"/> Declined to Specify	
Address				Apt.
City			State	Zip Code
Ethnicity <input type="radio"/> Not Hispanic or Latino(a) <input type="radio"/> Chicano(a) <input type="radio"/> Cuban <input type="radio"/> Mexican <input type="radio"/> Mexican American <input type="radio"/> Puerto Rican <input type="radio"/> Another Hispanic, Latino(a), Spanish Origin; <i>Please specify</i> _____ <input type="radio"/> Declined to Specify				
Race (Please Check all that Apply) <input type="radio"/> White <input type="radio"/> Black or African American <input type="radio"/> American Indian/Alaska Native <input type="radio"/> Asian Indian <input type="radio"/> Chinese <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Vietnamese <input type="radio"/> Other Asian; <i>If Other Asian, please specify</i> _____ <input type="radio"/> Native Hawaiian <input type="radio"/> Other Pacific Islander <input type="radio"/> Guamanian or Chamorro Samoan <input type="radio"/> Declined to Specify				
Preferred Language <input type="radio"/> English <input type="radio"/> Spanish		Relationship Status <input type="radio"/> Single <input type="radio"/> In a Relationship <input type="radio"/> Widowed <input type="radio"/> Divorced		Education Level (Highest Grade Completed) <input type="radio"/> 8th Grade or less <input type="radio"/> 9th <input type="radio"/> 10th <input type="radio"/> 11th <input type="radio"/> 12th
How did you hear about Community Health Connection? <input type="radio"/> Family/Friend <input type="radio"/> Health Fair/Event/Outreach <input type="radio"/> Newspaper/Magazine <input type="radio"/> Radio <input type="radio"/> TV <input type="radio"/> Website/Social Media <input type="radio"/> Other Advertising <input type="radio"/> Referral from another Provider			Do you or any members of your household have a relationship with Union Public Schools? <input type="radio"/> Yes <input type="radio"/> No	

**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 <input type="radio"/> Cell Phone <input type="radio"/> Alternate Phone <input type="radio"/> Mail <input type="radio"/> CHC Portal (Must provide a valid email)		How do we identify ourselves? <input type="radio"/> Community Health Connection <input type="radio"/> Doctor's Office <input type="radio"/> A Friend		
Cell Phone Number	Alternate Phone Number	Email Address		
Can we mail results to you 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.
- **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?

Private Insurance  Medicaid  Out-of-Pocket

**Insurance Information (Please fill out if you paying with Private Insurance or Medicaid)**

Insurance Company Name/Medicaid		Address		
City	State	Zip Code	Phone Number	
Effective/Issue Date	Group Number	Member Number/Claim Number	Patients Relationship to Subscriber	
Subscriber's Name		Subscriber's Employer		



**PATIENT HISTORY**

Name (Last, First, Middle)	Date of Birth	Social Security Number	Visit Date
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**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? <input type="radio"/> Yes <input type="radio"/> 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)**

<b>Please indicate if you have ever had any of the following (check all that apply):</b>		
<input type="radio"/> Heart Disease or Heart Attack	<input type="radio"/> Asthma, breathing problems, or other lung disease Do you use an inhaler? <input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Diabetes Do you use insulin? <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/> Heart Valve Problem	<input type="radio"/> Kidney Disease or Kidney Failure	<input type="radio"/> Herpes
<input type="radio"/> Blood Clot(s) in Veins or Lungs	<input type="radio"/> Bowel Disease (e.g. IBS, Crohn's)	<input type="radio"/> Chlamydia or Gonorrhea
<input type="radio"/> Stroke	<input type="radio"/> Rectal or Bladder Surgery	<input type="radio"/> Pelvic Inflammatory Disease
<input type="radio"/> Seizures or Epilepsy	<input type="radio"/> Thyroid Disease	<input type="radio"/> Hydrocele (enlarged testicle)
<input type="radio"/> High Blood Pressure	<input type="radio"/> Cushing's Syndrome	<input type="radio"/> Varicocele (enlarged veins in scrotum)
<input type="radio"/> High Cholesterol	<input type="radio"/> Long-term Steroid Medication Use	<input type="radio"/> Hernia
<input type="radio"/> Anemia (low iron)	<input type="radio"/> Cancer	<input type="radio"/> Uterine Abnormalities/Fibroids
<input type="radio"/> Gall Bladder Removal	<input type="radio"/> Migraines	<input type="radio"/> Ovarian Cysts
<input type="radio"/> Liver Problems	<input type="radio"/> Lupus	<input type="radio"/> Genital Warts
	<input type="radio"/> Severe Long-term Depression	
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 <input type="radio"/> Yes <input type="radio"/> No	Packs/Cans per day	For How Many Years	Date Quit	Other Nicotine (Vapor inhalers, e-cigarettes) <input type="radio"/> Yes <input type="radio"/> No
Alcoholic Beverages <input type="radio"/> Yes <input type="radio"/> No	Frequency (once a day, once a month, etc.)	Amount (2 drinks, 6-pack, etc.)		
Caffeinated Beverages <input type="radio"/> Yes <input type="radio"/> No	Type	Amount of Caffeine per Day		
Use street or IV drugs or abuse prescription drugs or other substances. <input type="radio"/> Yes <input type="radio"/> No	What type and how often used?			
Have/Had a partner who uses/used street or IV drugs. <input type="radio"/> Yes <input type="radio"/> No	What type and how often used?			

**Sexual History**

Have you ever had sex? <input type="radio"/> Yes <input type="radio"/> No	Are you currently sexually active? <input type="radio"/> Yes <input type="radio"/> No	Is/Are your partner(s): <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Transgender	What type(s) of sexual contact have you had? <input type="radio"/> Vaginal <input type="radio"/> Anal <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Sure	
Do you use condoms?	How often do you use condoms <input type="radio"/> Never <input type="radio"/> Sometimes <input type="radio"/> Almost Always <input type="radio"/> Always		



**PATIENT HISTORY**

Name (Last, First, Middle)	Date of Birth	Social Security Number	Visit Date
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**Menstrual/Contraceptive History**

When was the first day of your last menstrual period?	Was your last period Normal? <input type="radio"/> Yes <input type="radio"/> No	If No, please explain:
Do you have problems with your period? <input type="radio"/> Yes <input type="radio"/> No	If Yes, please explain:	
Have you ever used birth control? <input type="radio"/> Yes <input type="radio"/> No	If Yes, what kind of birth control have you used?	
Do you <b>currently</b> use birth control? <input type="radio"/> Yes <input type="radio"/> No	If Yes, what kind of birth control have you are you using?	
Have you ever had any problems with the birth control you currently use or any birth control you used in the past? <input type="radio"/> Yes <input type="radio"/> No	If Yes, please explain:	

**Pregnancy History**

Are you currently pregnant? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Extremely happy/excited <input type="radio"/> Somewhat happy/excited <input type="radio"/> Neither happy/excited or upset/worried <input type="radio"/> Somewhat upset/worried <input type="radio"/> 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

**FOR 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.  An emergency situation prevented signature of acknowledgement.  Communication barriers prevented signature of acknowledgement.  
 Other: \_\_\_\_\_



*\*May be required to show proof of Representative Status*