SCCHC

South Central Community Health Center

Patient Registration Chart Number ______________

Name: ______________________ ______________________ ______________
Last First Middle

Date of Birth: _____/_____/_____ Social Security Number: ______________ Sex: ________

Street Address: ______________________________

PO Box__________ City__________ State__________ Zipcode__________

Marital Status: __________ Student: ( )Full Time ( )Part Time Primary Language: __________

Ethnicity (check one) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ More than 1 race

Characteristics– Special Populations (Data used by South Central Community Health , a Federal Qualified Health Care Center which offers the Sliding Fee based on income along with number of family members.)

How long have you lived in the United States? ______years, ______months

Are you a US Veteran? ☐Yes ☐No

Household Income Range (circle one) <$11,500 $11,501-15,000 $15,001-20,000 $20,001-30,000 $30,001-40,000 $40,001-50,000 $50,001-60,000 $60,001-70,000 $70,001-80,000 $80,001-90,000 >$90,000

Persons In Household (circle one) 1 2 3 4 5 6 7 8 9 10 other __________

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry?

☐ Yes ☐ No If yes, which applies? ☐ Year Round Employment (permanent residence in area) ☐ Migrant (establishes temporary residence in area) ☐ Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (check one)

☐ Public Housing ☐ Homeless Shelter ☐ Doubled Up (live with another person or family unit)
☐ Rent or own home ☐ Street ☐ Transitional (live place to place) ☐ Other __________

Home Telephone: (___)__________ Work Phone: (___)__________ Cell Phone: (___)__________

Patient's Employer: ______________ Address: ______________

Spouse's Name: ______________ Date of Birth: _____/_____/_____

Spouse's Employer: ______________ Address: ______________

In case of Emergency, Center may Contact: Name: ______________ Telephone: (___)__________

Responsible Party Information: (Who Pays the Bills?) Name: ______________

Telephone: (___)__________ Work Phone: (___)__________ Relationship__________

Address: ______________ City__________ State______ Zipcode__________

Employer: ______________ Social Security Number: ______________ Date of Birth: ____/____/____

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Full Name: ______________ Telephone: (___)__________

Relationship to Patient: ______________ Work Phone: (___)__________

Parent/Legal Guardian of Minor (2) [If Applicable]

Full Name: ______________ Telephone: (___)__________

Relationship to Patient: ______________ Work Phone: (___)__________

(IMPORTANT NOTICE: The Information Listed Above Is Not Authorization and/or Designation of a Personal Representative)

Is this visit due to an Accident/Injury: Yes______ No______ If yes, Date of Injury: _____/_____/_____

I certify that the information given above is true and correct ______________ ____/____/____
(Patient Signature) (Date)

______________ ______________ ____/____/____
(Parent/Guardian signature if patient a minor) (Print Name) (Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

(Rev SEPT2014)

SOUTH CENTRAL COMMUNITY HEALTH CENTER

Chart# ______________

HEALTH HISTORY

Name: ____________________ Date of Birth: ______________ Date: ______________

Previous Physician: ______________ Last visit: ______________ Reason: ______________

Race: ____________________ Marital status: ______________ Gender: ______________

MEDICAL HISTORY:

Have you ever been diagnosed with any of the following diseases?

1. ☐ Abuse (physical, sexual, verbal or emotional)	18.☐ Hernia
2. ☐ Alcoholism	19.☐ High cholesterol, High blood pressure, Stroke
3. ☐ Anemia, Sickle Cell Disease or Trait, Blood disorder	20.☐ HIV, AIDS
4. ☐ Anorexia, Bulimia, other eating disorders	21.☐ Kidney or bladder problems, stones, dialysis
5. ☐ Arthritis, joint problems, back problems	22.☐ Migraine or severe headaches
6. ☐ Asthma, Bronchitis, other breathing problems	23.☐ Pain or numbness in arms or legs
7. ☐ Birth defects, genetic problems, Cystic Fibrosis	24.☐ Physical disability
8. ☐ Bleeding problems, blood clots in legs or lung, etc.	25.☐ Prostate problems
9. ☐ Bowel problems	26.☐ Rectal pain or bleeding, hemorrhoids or "piles"
10.☐ Breast lumps, discharge, tenderness, other problems	27.☐ Rheumatic fever
11.☐ Cancers, tumors (including cervical or uterine)	28.☐ Seizures ("fits")
12.☐ Depression, anxiety, mental illness	29.☐ Stomach pain, cramps, ulcers
13.☐ Diabetes (sugar problems)	30.☐ Thoughts of harming self or others
14.☐ Eye problems, blurred vision or spots	31.☐ Thyroid problems
15.☐ Fainting, dizzy spells	32.☐ Transfusions of blood or blood products
16.☐ Heart disease, heart problems, chest pain	33.☐ Tuberculosis
17.☐ Hepatitis, liver problems, gallbladder problems	

Do you have any other illness for which you see a doctor regularly? ____________________

Do you have any of the following problems?

Hearing Loss	( ) Yes	( ) No	Last exam ______________
Vision Loss	( ) Yes	( ) No	Last exam ______________
Dental problems	( ) Yes	( ) No	Last exam ______________

Screening Tests:	**When**	**Where**
Last Mammogram	______________	______________
Bone Density	______________	______________
Stress Test	______________	______________
Last Pap smear	______________	______________
Last Colonoscopy	______________	______________
Last Chest X ray	______________	______________

Other Physicians: (Opthalmologists, Cardiologists, Urologists, etc...)

______________ ______________ ______________

______________ ______________ ______________

SURGICAL HISTORY: (Hysterectomy, gallbladder removal, appendectomy, etc...)

Please list all surgeries and dates:

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Health History continued -

CHILDHOOD DISEASE / Infectious Diseases

( ) Mumps ( ) Chickenpox ( ) Measles ( ) Rubella ( ) Rheumatic Fever
( ) Tetanus ( ) Whooping Cough ( ) Meningitis ( ) Hep A & B ( ) Scarlet Fever
( ) Other ____________________

FAMILY HISTORY:

Have any of your family members been diagnosed with the following diseases and if yes, what is their relationship to you?

		Relationship			Relationship
AIDS or HIV positive	( ) Yes ( ) No	____________	High Blood Pressure	( ) Yes ( ) No	____________
Asthma	( ) Yes ( ) No	____________	Kidney Disease	( ) Yes ( ) No	____________
BPH/Prostatitis	( ) Yes ( ) No	____________	Liver Disease	( ) Yes ( ) No	____________
Blood Clots	( ) Yes ( ) No	____________	Lupus or rheumatoid arthritis	( ) Yes ( ) No	____________
Cancer	( ) Yes ( ) No	____________	Seizure Disorder	( ) Yes ( ) No	____________
Chronic Bronchitis	( ) Yes ( ) No	____________	Stroke	( ) Yes ( ) No	____________
Emphysema	( ) Yes ( ) No	____________	Thyroid Disease	( ) Yes ( ) No	____________
Diabetes	( ) Yes ( ) No	____________	Tuberculosis	( ) Yes ( ) No	____________
Glaucoma	( ) Yes ( ) No	____________	Ulcer/Reflux	( ) Yes ( ) No	____________
Heart Disease	( ) Yes ( ) No	____________	High Cholesterol	( ) Yes ( ) No	____________

SOCIAL HISTORY:

Caffeine? ( ) Yes ( ) No What? ____________ How much? ____________ How long? ____________

Tobacco Use? ( ) Yes ( ) No What? ____________ How much? ____________ How long? ____________

Alcohol Use? ( ) Yes ( ) No What? ____________ How much? ____________ How long? ____________

Other drug use? ( ) Yes ( ) No What? ____________ How much? ____________ How long? ____________

Exercise? ( ) Regularly ( ) Sporadically ( ) Never

Practice firearm safety? ( ) Yes ( ) No
Carbon monoxide detectors in the home? ( ) Yes ( ) No
Do you wear seat belts? ( ) Yes ( ) No
Smoke Detectors in the home? ( ) Yes ( ) No
Exposure to secondhand smoke? ( ) Yes ( ) No

Occupation: ______________________________

Occupation hazards: ( ) Stress ( ) Hazardous substances ( ) Heavy Lifting

Highest level of education completed: ______________________________

Religious Affiliation: ______________________________

Do you have a healthcare power of attorney? ( ) Yes ( ) No

Do you have a living will? ( ) Yes ( ) No

Allergies:

Are you allergic to or do you have reactions to any of the following?

( ) Penicillin ( ) Cephlasporins ( ) Bee Stings
( ) Sulfa ( ) Tetracycline ( ) Foods
( ) Ampicillin ( ) IVP dye ( ) Pollen/grass/trees

Other Allergies: ______________________________

Health History continued -

MEDICATIONS: (prescriptions, over the counter medications, herbal supplements)

NAME	DOSE	HOW OFTEN?

IMMUNIZATIONS:
Please list date given and where:

Tetanus ____________________

Pneumonia ____________________

Flu ____________________

Hepatitis A Series ____________________

Hepatitis B Series ____________________

TB Tine ____________________

Chicken Pox ____________________

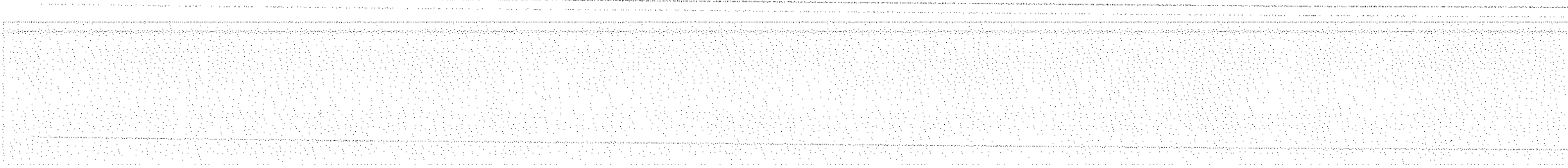
MMR ____________________

Other ____________________

Patient Attestation

I ______________________________ attest that the information I have listed is accurate to the to the best of my knowledge and ability. I understand that this information will be used in any treatment or care plans advised by the physician.

Patient Signature: ______________________________ **Date:** ____________________



South Central Community Health Center

General Consent Authorization and Agreement

General Consent for Treatment:

This is to certify that I (we) the undersigned, voluntarily consent to the administration and performance of diagnostic procedures and medical treatment by the providers and employees of South Central Community Health Center (SCCHC) as may, in their professional judgement be deemed necessary or beneficial to provide for my healthcare including but not limited to, the power to provide for such health care at any hospital or other institution. I (we) acknowledge that no guarantees have been made to me (us) as to effect of such examination or treatment.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I am indicating that (I) am fully informed as to the contents of the document and I understand the full scope and importance of this grant of powers to the healthcare providers of SCCHC.

Assignment of Insurance Benefits:

I hereby authorize payment directly to the healthcare providers of SCCHC all benefits, if any, otherwise payable to this facility including major medical insurance for services rendered. I understand that I am financially responsible for charges not paid under this assignment.

Financial Agreement:

The undersigned agree, jointly, and severally, whether they sign as guarantor or as patient, that in consideration of the services rendered to the patient, they do hereby guarantee payment to SCCHC. I (we) acknowledge that payment is due at time of treatment unless other arrangements are made. I (we) accept full financial responsibility for all charges not covered by insurance. I understand that I am financially responsible for all charges regardless of insurance payment.

Medical Information:

I hereby authorize SCCHC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic. I specifically authorize the physicians of SCCHC to disclose information in my medical records, including copies to: government agencies or programs, managed care organizations and/or insurance companies, the utilization review organization contracted by my employer, insurance company or government agency or program, or to physicians or other health care institutions responsible for further care, consultations, or follow-up treatment to serve the goal of continuation of care.

The authorization includes the release of medical records and/or information concerning treatment rendered by the providers of SCCHC.

Print Patient's Name	Patient's Signature	Date
Parents Name if under 18	Parent Signature	Date

Notice of Privacy Practices Acknowledgement

SOUTH CENTRAL COMMUNITY HEALTH CENTER
102 W. Southern Avenue
Raeford, NC 28376
(910) 565-2959
(910) 565-2967

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Relationship to Patient: ______________________

Signature: ______________________

Date: ____________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

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Medical Records Release
Individual Authorization

PRINT OR TYPE CLEARLY FOR FAXING

I hereby knowingly and voluntarily authorize:

Phone:
Fax:

To release the following information to: South Central Community Health Interventions
102 W. Southern Ave.
Raeford, NC 28376
910-565-2959 Phone/910-565-2967 Fax

Describe the information to be released: (Check all that apply)

- ☐ General Medical Record(s)
- ☐ History and Physical Results
- ☐ Diagnostic Test Results – Specific Type of Test(s): ______
- ☐ Other (Specify): ______
- ☐ Progress Notes
- ☐ Immunizations
- ☐ Prenatal Records
- ☐ Consultations

I specifically consent to release information relating to (check selection(s))
☐ STD ☐ HIV/AIDS ☐ TB ☐ Drug/Alcohol ☐ Mental Health ☐ WIC Eligibility ☐ Early Intervention

Purpose(s) of Release:

- ☐ Permanent Transfer
- ☐ Legal Investigation
- ☐ Continuity of Care
- ☐ Personal Use
- Other (Specify) ______

This authorization expires on the following date or event ______

I understand that this authorization will expire in six (6) months if no date or event is listed.

I understand that the information used or disclosed because of this form may be subject to re-disclosure by the receiving establishment and may no longer be protected by the privacy regulations.

I understand that I have the right to withdraw this authorization in writing.

______ Print Name of Patient ______ Date of Birth

Address ______

______ Signature of Patient ______ Date

Phone # ______

______ Signature of Witness ______ Date

- ☐ Mail
- ☐ Fax
- ☐ Pick Up

If this authorization is signed by a personal representative of the patient, a description of the representative's authority.

Thank You,

______
Authorizing Physician

PLEASE NOTE: A copy of this authorization must be given to the patient.