Lifecare
Family Health & Dental Center

Patient Name: _____ **Date of Birth:** _____

SECTION 1: PROBLEM LIST

Please list any medical conditions that you have ever been diagnosed with (diabetes, high blood pressure, etc.). Please include the date you were diagnosed.

Diagnosis/Date	Diagnosis/Date

Do you see another medical provider for treatment of a medical condition? [ ] Yes [ ] No

If yes, please list them here:

Medical Specialist: _____

Phone Number: _____ Specialty: _____

Medical Specialist: _____

Phone Number: _____ Specialty: _____

Medical Specialist: _____

Phone Number: _____ Specialty: _____

SECTION 2: ALLERGIES

Please list any medication allergies & the reaction you have when taking these medications.

Allergy:	**Reaction:**	**Allergy:**	**Reaction:**

Do you have a latex allergy? [ ] Yes [ ] No

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SECTION 3: FAMILY HISTORY

Place an "X" in any box that applies to you or any family member who has had any of the following conditions. (S= Self, M= Mother, F= Father, O= Other Immediate Family Members)

Diagnosis	S	M	F	O	Diagnosis	S	M	F	O
Diabetes					Asthma				
Glaucoma					Emphysema				
Kidney disease					TB				
High Blood Pressure					Systemic Lupus				
Heart Attack					Sickle Cell Trait				
Coronary Artery Disease					Thyroid Disease				
Heart Murmur					Arthritis				
Mitral Valve Prolapse					Stroke				
Prosthetic Heart Valve					Neurological Disorder				
Heart Stents					Bleeding/Hemophilia				
Pacemaker					Leukemia				
Rheumatic Fever					HIV/AIDS				
Alcohol/Substance Abuse					Eating Disorder				
Liver Disease					Mental Illness				
Hepatitis A/B/C					ADD				
RSV					ADHD				
Other:									

Family Member	Living (yes or no)	Cause of death	Age at death
Mother			
Father			

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SECTION 4: PERSONAL/SOCIAL HISTORY

Education: What is your highest level of education?

[ ]Less than High School [ ]High School [ ]Some College [ ]College Degree

Care Giver: Do you have someone that cares for you in your home? [ ] Yes [ ] No
If yes, whom? _____

Tobacco:	**Alcohol:**
[ ] I have never used any tobacco [ ] I smoke or chew tobacco Amount per day:_____ • Started at age:_____ [ ]I quit using tobacco • Date quit:_____	[ ]I have never consumed alcohol [ ]I drink alcohol • How often:_____ • Amount:_____ [ ] I quit drinking • Date Quit:_____
Drug Usage:	**Caffeine:**
[ ] I have never used any illicit drugs [ ]I am currently using illicit drugs • Drugs_____ [ ] I quit using drugs • Drugs:_____ • Date Quit:_____	[ ]I do not drink caffeine [ ]I drink caffeinated beverages Drinks: [ ] Soda [ ] Coffee [ ] Energy • Amount per day:_____

Do you have a cultural or language barrier? [ ] Yes [ ] No

If yes, please explain: _____

Housing:
[ ]Apartment
[ ]Correctional Institution
[ ]Group Home
[ ]Homeless
[ ]Private House
[ ]Public Housing

Current Work Status
[ ]Full Time
[ ]Part Time
[ ]Unemployed
[ ]Disabled
[ ]Retired
[ ]Self-Employed

Financial Struggles
[ ]Food
[ ]Housing
[ ]Utilities
[ ]Healthcare
[ ]Medications
[ ]Fixed Income

Patient Name: _____ **Date of Birth:** _____

Are you worried about losing your housing? [ ] Yes [ ] No [ ] Choose not to answer

At any point in the past 2 years, has season or migrant farm work been your family's main source of income? [ ]Yes [ ]No [ ]Choose not to answer

Seat Belt Usage: **[ ]**Always [ ]Usually [ ]Occasionally [ ]Never

Guns in the Home: **[ ]**None [ ]Kept locked up [ ]Not kept locked up

Sexual Activity: **[ ]**Never [ ]Currently Sexually Active [ ]Not Currently Sexually Active

SECTION 5: MEDICATIONS

Local Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

List all prescription medications, over-the-counter medications, or supplements that you are currently taking on a regular basis. Please include the prescribing doctor for any prescription medications.

[ ]I do not take any medications or supplements on a regular basis.

Medication Name	Dosage	Frequency

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SECTION 6: WOMEN ONLY – men skip to section 7

- How many pregnancies have you had? _____

  How many living children do you have? _____

  Did you have a C-section? [ ] Yes [ ] No

  If yes, what year(s)? _____

- Have you ever had a miscarriage? [ ] Yes [ ] No

  If yes, what year(s)? _____

- Have you ever had an abortion? [ ] Yes [ ] No

  If yes, what year(s)? _____

- Are you currently: [ ]pre-menopausal [ ]menopausal [ ] post-menopausal
- Date of last menstrual cycle: _____[ ] regular [ ] irregular

- Date of last Pap smear: _____ Where was this done _____
  Results were: [ ]Normal [ ]Abnormal

  If abnormal please explain: _____

- Date of last mammogram: _____Where was this done? _____

  Results were: [ ]Normal [ ]Abnormal

  If Abnormal please explain: _____

Patient Name: _____ **Date of Birth:** _____

SECTION 7:SURGICAL HISTORY

Please list all previous surgeries & the year of the surgery here.

Type of surgery	Year

SECTION 8: HEALTH MAINTENANCE

Date of most recent:

- Eye Exam:_____ Where: _____

  Results: Normal / Abnormal

  If abnormal please explain: _____

  _____

- Dental Visit:_____ Where: _____

  Results: Normal / Abnormal

  If abnormal please explain: _____

  _____

- Colonoscopy:_____Where: _____

  Results: Normal / Abnormal

  If abnormal please explain: _____

  _____

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SECTION 9:

- Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

  [ ]Yes, it has kept me from medical appointments
  [ ]Yes, it has kept me from non-medical meetings, appointments, work, or other things.
  [ ]No [ ]Choose not to answer

- How often do you see or talk to people that you care about and feel close to? (for example: talking to friends on the phone, visiting friends or family, going to church or club meetings)?

  [ ]Less than once a week [ ] 1-2 times weekly
  [ ]3-4 times weekly [ ]5-6 times weekly
  [ ]Every day of the week

- Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
  [ ]Not at all [ ]A little bit [ ]Somewhat
  [ ]Quite a bit [ ]Very much [ ]I choose not to answer

- In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correction facility?
  [ ]Yes [ ]No [ ]I choose not to answer

- Are you a refugee? [ ]Yes [ ] No [ ] I choose not to answer
- Do you feel physical and emotionally safe where you are currently living?

  [ ]Yes [ ]No [ ] Unsure [ ]I choose not to answer

- In the past year, have you been afraid of your partner, or ex-partner?
  [ ]Yes [ ]No [ ]Unsure [ ]I choose not to answer

Patient Name: _____ **Date of Birth:** _____

HOW SHOULD THE CLINIC CONTACT YOU?

I wish to be contacted in the following manner:

(PLEASE CHECK ALL THAT APPLY)

___HOME:

Telephone number: _____

___OK to leave a message with detailed information.

___OK to leave a message with call back number only.

___ Do not leave a message

___ CELL PHONE:

Telephone number: _____

___OK to leave a message with detailed information.

___OK to leave a message with call back number only.

___ Do not leave a message

___ WORK PHONE:

Telephone number: _____

___OK to leave a message with detailed information.

___OK to leave a message with call back number only.

___ Do not leave a message

___BY MAIL:

Address: _____

Patient Signature: _____ Date: _____

I have been offered a copy of Lifecare FHDC's Notice of Privacy Practice.

Patient Signature: _____ Date: _____

Patient Name: _____ **Date of Birth:** _____

HIPAA
LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Allow the clinic to discuss your health information with the individuals listed below)

Purpose of Request (whom is authorized to receive health information) - I authorize the practice to disclose or provide health information, about me to the individual(s) listed below. (Please list each family member, friend, or other individual to receive Protect Health Information).

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Description of Information to be disclosed – I authorize the practice to disclose the follow Protected Health Information about me to the person or persons identified above.

[ ] Entire patient record, **or** circle **only** those items of the record to be disclosed

[ ] Office notes [ ] lab results [ ] x-ray results
[ ] record of HIV and communicable disease record
[ ] hospital / nursing home / home health / hospice and other physician records
[ ] records of mental health or substance abuse treatment.

[ ] Other (please specify): _____

Purpose of disclosure (please record the purpose of the disclosure, or check patient request):

[ ] Patient request
[ ] Other (please specify):_____

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Patient Name: _____ **Date of Birth:** _____

HIPAA
LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

Please list the date of expiration if earlier than the end of the calendar year:

_____

Right to revoke or terminate: as stated in our Notice of privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your health care provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning Statement: The practice places no condition to sign this authorization on the delivery of health care or treatment.

Re-disclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature: _____ Date: _____ (must be signed and dated each year)

You have a right to receive a copy of signed authorization upon request

Patient Name: _____ **Date of Birth:** _____

AGREEMENT OF TREATMENT EXPECTATIONS AND MEDICAL HOME RESPONSIBILITIES

This is an agreement between two parties: the Health Center and the Patient.

The purpose of this document is a positive one. It attempts to make the clear rights and responsibilities of both parties. Is says *who* is to do *what*.

A medical home is a care team working to provide you with the best care possible. We want to include you in making health care decisions. We will help you coordinate your care with providers outside of Lifecare when needed. We offer clinical advice during and after hours along with early morning appointments.

We promise to treat you to the best of our abilities, consistent with the standards of care in our community. You, in turn promise to be as understanding, cooperative, and responsible as possible.

This Health Center has a zero tolerance for violence or threat of violence of any kind. Therefore, there will not be any attempt or threat to kick, hit, or otherwise harm any staff member, patient, or visitors. Furthermore, neither party will yell or use profanity when addressing any staff member, patient, or visitors.

I have read (or have had read to me) the "Agreement of treatment Expectations" and fully understand its contents. I have been given an opportunity to ask questions. Any violation of this agreement may result in permanent dismissal from the office.

Patient Name: _____ Date: _____

If not the Patient, Relationship to Patient: _____

Health Care Witness: _____

Patient Name: _____ **Date of Birth:** _____

FINANCIAL AGREEMENT

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc. I authorize the Lifecare Family Health & Dental Center, Inc. (Lifecare FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

Lifecare FHDC has made prior arrangements with many health plans to accept direct payments. Lifecare FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and **assign benefits, otherwise payable to me, to the physician or group indicated on the claim**. I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. Lifecare FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, Lifecare FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that Lifecare FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

Lifecare FHDC offers reduced rates to qualifying uninsured patients. I understand that unless other arrangements have been made in advance by either me or my health coverage provider, **payment is due at the time of service**. For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience Lifecare FHDC will accept Visa, MasterCard, Cash, and Personal Check. **There will be a $10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.**

I understand that Lifecare FHDC is not in the business of extending credit and I agree to pay the above health center at the time its bill is presented. If prompt payment is not made, Lifecare FHDC may take action to collect its charges. In extreme cases of non-payment, Life Care FHDC reserves the right to dismiss the patient from the health center.

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY. I AGREE TO PAY SAID CHARGES.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____