COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Date: _____

REGISTRATION FORM

1. Name (First and Last): _____ M.I. _____ Date of Birth:_____
2. Address: _____
   Apartment: _____ City/State: _____ Zip Code: _____
   ☐ Home Phone: _____ ☐ Cell Phone:_____ ☐ Work Phone: _____
3. E-mail address: _____ Social Security: _____ - _____ - _____
4. *Gender Identity: ☐ Female ☐ Male ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Other ☐ Decline to answer
5. Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose
6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
7. Race (Check all that apply):
   ☐ Asian ☐ Black ☐ White
   ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

   Ethnicity (Check one): ☐ Hispanic/Latino ☐ NOT Hispanic/Latino
8. Language:
   ☐ Albanian ☐ English ☐ Hmong ☐ Laotian ☐ Sign Language
   ☐ Arabic ☐ French ☐ Japanese ☐ Portuguese ☐ Tagalog
   ☐ Cambodian (Khmer) ☐ German ☐ Korean ☐ Russian ☐ Vietnamese
   ☐ Chinese ☐ Greek ☐ Kreyól ☐ Spanish ☐ Other
9. Is the patient a US citizen? ☐ Yes ☐ No
10. Employment Status*: ☐ Employed ☐ Self-employed ☐ Disabled ☐ Retired ☐ Student (Part time / Full time)
11. Emergency Contact name: _____ Phone: _____
12. Relationship to emergency contact: _____ Mother's maiden (last) name: _____

Parent/Legal Guardian Information (*complete only if patient is a minor*)
Mother's Name (First & Last): _____
Father's Name (First & Last):_____
Guardian's Name (First & Last): _____
Relationship to patient: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other: _____
Social Security: _____ - _____ -_____ Identification: _____

13. Annual Gross Monthly Income (before taxes): _____ Number of people supported in household:_____
14. Do you have insurance? ☐ Yes ☐ No If yes, what type of insurance? _____

Name of Policy Holder_____ Date of Birth_____

15. Are you a military veteran? ☐ Yes ☐ No
16. Are you homeless**? ☐ Yes ☐ No If yes, choose one of the following: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

*Employment Status:

- Employed – You earn a living either working part-time or full-time for another individual, company or organization.
- Self-employed – You earn a living working from your own business and not earn salary or commission from another individual.
- Disabled – You receive monthly payments from the government for a disability
- Retired – You have retired from working and receive a social security check monthly
- Full-time/Part-time Student – You are enrolled in an accredited school on either a part-time (less than 12 credit hours) or full-time (12 credit hours or more).

**Homeless Status:

- Shelter – You are living in an organized shelter for homeless persons.
- Transitional Housing – You are residing in a small unit that helps a person transition from homelessness to permanent housing.
- Double Up – You are living with other individuals in their home and/or apartment.
- Street – You are living outdoors, in a car, in an encampment (tent city), in a makeshift housing/shelter.
- Other – You are living in a single room occupancy hotel or motel or other day-to-day paid for housing.

_____
Patient/Parent/Legal Guardian Signature

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT CONSENTS AND ACKNOWLEDGEMENTS

		INITIAL
I.	**Consent for Treatment** I hereby give consent and authorize treatment at Community Health Centers of Pinellas, Inc. for myself, the patient.	
II.	**Consent for Treatment of a Minor** I, as the parent or legal guardian of the patient, do hereby give my consent and authorize treatment. Furthermore, I grant permission for _____ to authorize Medical Treatment in my absence.	
III.	**Medical Home:** I choose to participate in the patient-centered medical home.	
IV.	**Notice of Privacy Practices** I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.	
V.	**Release of Information** • Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. • If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS. I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations.	
VI.	**Disclosure to Friends and/or Family Members** I give permission for my Protected Health Information to be disclosed for purposes of coordinating health care needs, communicating results, findings and care decisions to the friends and/or family members listed below:	

Name	Relationship	Contact Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

		INITIAL
VII.	Consent for Use and Disclosure of Protected Health Information (PHI)	

	Yes	No
May we call your job and leave a message? If yes, at what number? _____		
May we call your home and leave a message? If yes, at what number? _____		
May we leave a message concerning medical information on your cell phone? If yes, at what number? _____		

VIII. Consent to E-mail or Text Message for Appointment Reminders and Other Healthcare Communications.

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at anytime I provide an email or text address at which I may be contracted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or mobile number from the practice.

I consent to receive TEXT messages for: appointment reminders, feedback, and general health reminders/information at this mobile number: _____.

I consent to receive EMAIL messages for: appointment reminders, feedback, and general health reminders/information at this email address: _____.

Community Health Centers of Pinellas, Inc. does not charge for this service, but standard text messaging and data rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

IX. Revocation (If you DO NOT want to receive text messages or email from us about future appointment reminders, feedback, and general health).

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via TEXT messaging.

_____ _____
Signature of Patient or Parent/Guardian Date

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via EMAIL.

_____ _____
Signature of Patient or Parent/Guardian Date

X. Patient Rights, Responsibilities and Information and Patient Centered Medical Home

These documents are posted in the lobby. I acknowledge that I have received a copy of each.

XI. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)

Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury.

In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Community Health Centers of Pinellas locations and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification.

Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives.

☐ I have an advanced directive.

☐ I do not have an advanced directive.

☐ I would like to receive information on advanced directives.

XII. Residents and Students

I understand that Community Health Centers of Pinellas, Inc. supports the education of medical professionals and maintains Residents and Students that may assist in relation to care.

_____ _____
Signature of Patient or Parent/Guardian Date

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 2)

Today's Date: _____

Please answer the following questions to the best of your ability. All your answers will be kept private.

Over the last two (2) weeks, how often have you been bothered by any of the following problems? (Circle a number)

	0 days a week	1-3 days a week	4-5 days a week	6-7 days a week
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3

Add two circled numbers together.

If your total number is 3 or higher, please turn paper over and complete PHQ-9. Thank you.

Total

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ – 9)

Today's Date: _____

Please answer the following questions to the best of your ability. All your answers will be kept private.

Over the last two (2) weeks, how often have you been bothered by any of the following problems? (Circle a number)

	0 days a week	1-3 days a week	4-5 days a week	6-7 days a week
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of total, please refer to scoring card below)

Total _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

NEW PATIENT HEALTH RISK ASSESSMENT

Patient Name: _____

Date of Birth: _____

Today's Date: _____

1. Who was your previous provider/physician? _____
2. When did you last see your previous provider/physician?_____
3. What languages do you speak?_____What languages do you read?_____
4. What is your highest level of education? ☐ Grades 1-6 ☐ Grades 7-12 ☐ College ☐ No Formal Education
5. How do you prefer to learn? ☐ Person to Person ☐ Hand-outs ☐ Video/audio tapes
6. Do you have any special educational needs we should be aware of in the following areas?
   ☐ Hearing ☐ Sight ☐ Speech ☐ Spiritual ☐ Cultural Beliefs ☐ None
7. At this time do you have any limitations or emotional barriers that may affect your ability to learn? ☐ Yes ☐ No
8. When you are given instructions from your doctor or pharmacist, how often do you need someone to help you?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always
9. Are you allergic to any medications, foods, etc? ☐ Yes ☐ No If yes, explain: _____
10. Are you taking any prescribed, OTC, or herbal medicines? ☐ Yes ☐ No If yes, please list below:

Medicine/Vitamin/Supplement Name	Dose-How much you take	How often do you take it?	Refill needed?

11. Do you have or have you ever had any of the following?

☐ High Blood Pressure
☐ Heart Disease
☐ Diabetes
☐ High Cholesterol/Lipid Levels
☐ An Exercise Program
☐ Alcohol Use Now: Amount and Frequency: _____
☐ Alcohol Use in the Past
☐ Tobacco Use Now: Amount and Frequency: _____
☐ Tobacco Use in the Past
☐ Street Drug Use Now: Type, Amount and Frequency:
_____
☐ Street Drug Use in the Past
☐ Anemia
☐ GERD / Reflux / Ulcer
☐ Other: _____

☐ Tuberculosis/Positive TB Skin Test
☐ Cancer
☐ Kidney Disease/Kidney Stones
☐ Hepatitis/Liver Disease
☐ Asthma
☐ Blood Transfusion
☐ AIDS/HIV
☐ Epilepsy/Seizures
☐ Mental Health Problems/Depression/Anxiety
☐ Osteoporosis
☐ Chronic Back Pain
☐ Migraine / Headache
☐ Pneumonia
☐ COPD

12. Have you ever been a victim of abuse or neglect? ☐ Yes ☐ No
13. Have you had any falls, trauma or other injury? ☐ Yes ☐ No
14. Have you ever been in the hospital? ☐ Yes ☐ No
    When?_____ Where? _____Why?_____
15. Have you ever had any surgeries? ☐ Yes ☐ No

NEW PATIENT HEALTH RISK ASSESSMENT

LIFESTYLE:

16. What is your usual diet? ☐ Regular ☐ Low Salt ☐ Akins Diet ☐ Low Cholesterol ☐ Vegetarian ☐ Other:_____
17. Do your daily activities require that you stay in the sun often? ☐ Yes ☐ No
18. Have you ever been exposed to asbestos, radiation, chemicals or fumes? ☐ Yes ☐ No
19. Do you have difficulty doing any of the following things for yourself? ☐ Bathing ☐ Dressing ☐ Shopping ☐ Eating

Your provider would like to ask you about your sexual history and hopes you will feel comfortable discussing the following:

20. Are you sexually active? ☐ Yes ☐ No
21. What is your current contraceptive method?_____
22. At what age did you first have intercourse?_____
23. Number of partners in the past 5 years_____
24. Have you had sex with a man who has sex with men? ☐ Yes ☐ No
25. Have you had sex with a person with HIV/AIDS? ☐ Yes ☐ No
26. Have you had sex with an injecting drug user? ☐ Yes ☐ No

SOCIAL HISTORY:

27. Are you currently employed? ☐ Yes ☐ No
29. Your occupation_____
30. Do you live alone? ☐ Yes ☐ No
31. Living Arrangements: ☐ Housed ☐ Emergency Shelter ☐ Transitional Housing ☐ Doubled Up ☐ Unsheltered

SAFETY:

32. Do you wear your seatbelt? ☐ Yes ☐ No
33. Do you have a smoke detector? ☐ Yes ☐ No

FOR WOMEN ONLY:

34. Pap Smear ☐ Yes ☐ No Date:_____
35. Mammogram ☐ Yes ☐ No Date:_____
36. Date Last Period_____
37. Any menstrual problems or recent changes? ☐ Yes ☐ No
38. How many times have you been pregnant?_____
39. How many full term pregnancies have you had?_____
40. How many premature pregnancies have you had?_____
41. How many abortions have you had?_____
42. How many miscarriages have you had? _____
43. How many ectopic pregnancies have you had?_____
44. How many of your children are living? _____

FAMILY HISTORY:

45. Have any of your blood relatives (parents, siblings) had any of the following?:

	Mother	Father	Brother	Sister
Cancer	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐

Have any of your blood relatives (including grandparents, aunts, uncles, etc.) had any of the following?

☐ Allergies ☐ Genetic Disease ☐ Seizures
☐ Arthritis ☐ Hepatitis ☐ Sickles Cell Anemia
☐ Asthma ☐ HIV/AIDS ☐ Stroke
☐ Bleeding/Clotting Disorder ☐ Kidney Disease ☐ Thyroid Disease
☐ Depression ☐ Mental Health Problems ☐ Other: _____

46. Do you have an Advance Directive or Living Will? ☐ Yes ☐ No