

**PATIENT INFORMATION**

Last Name		First Name		MI	Date of Birth
Street Address		City	State	Zip Code	
Home Phone Number: _____ Cell Phone Number: _____ OK to send text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What sex were you assigned at birth? (Check one): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Decline to state <input type="checkbox"/> Other (Please specify) _____			What pronoun do you use? (Check one): <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Decline to state <input type="checkbox"/> Other (Please specify) _____		
What is your sexual orientation? (Select all that apply): <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Queer <input type="checkbox"/> Bisexual <input type="checkbox"/> Don't Know <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other (Please specify) _____					
What is your current gender identity? (Check all that apply): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Transgender Male/TransMan/FTM <input type="checkbox"/> Transgender Female/Transwoman/MTF <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other (Please specify) _____					
Marital Status (Check one): <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated				Social Security Number:	
Emergency Contact (if none must state none):					
Last Name		First Name	Relationship to patient		Phone Number
<b>For patients under 18, Parent or Legal Guardian Information:</b>					
Last Name		First Name	Relationship to patient		Phone Number
Insurance Type (Check one): <input type="checkbox"/> MediCal/Partnership <input type="checkbox"/> Private Insurance <input type="checkbox"/> Covered California <input type="checkbox"/> Medicare <input type="checkbox"/> None <input type="checkbox"/> Other (Please specify) _____					
Email Address:					
Race (Check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> White <input type="checkbox"/> Other (Please specify) _____ <input type="checkbox"/> Decline to state					
What is your ethnicity? (Check one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino		What is your primary language:		Do you need a translator for your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What pharmacy would you like us to send your medication to?					

**Additional Patient Information (Please answer ALL questions)**

CommuniCare is a non-profit. By answering these questions, you will give us information needed to acquire grant funds that help uninsured and underinsured people in our community. Please help us serve you and our community by providing us with this information. This information will become a part of your confidential medical record.

Are you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where are you currently living? (Check all that apply): <input type="checkbox"/> Home/Apartment <input type="checkbox"/> Shelter <input type="checkbox"/> Staying with friends/family <input type="checkbox"/> Outside (Street/Car) <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Other (Please specify) _____
Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a seasonal/migrant agricultural worker? (Check all that apply): <input type="checkbox"/> Seasonal agricultural worker: my main job is agriculture and I don't work year-round <input type="checkbox"/> Migrant agricultural worker: my main job is agriculture and I move to find my jobs
How many people are in your household?	How much income did everyone in your house get last month before taxes?

**PLEASE TURN OVER AND CONTINUE ON THE BACK**

**CONSENTS:**

To provide treatment, bill your insurance, or release information required by your insurance carrier, etc., we must receive your consent by initialing the areas indicated and by providing your signature below.

**Assignment of Benefits:** I assign to CommuniCare Health Centers (CCHC) all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by CCHC. \_\_\_\_\_ (initials)

**Consent of Treatment:** I authorize CCHC and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of CCHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by CCHC personnel. \_\_\_\_\_ (initials)

**Patient Acknowledgement:** I acknowledge receiving notice that under federal law relating to the operation of health centers, the Federal Tort Claims Act (FTCA) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions within the scope of deemed employment by any volunteer of a deemed health center who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. (See Public Health Service Act subsection 224(q), codified at 42 U.S.C. § 233(q) This acknowledgment of notification of the limitation on liability is being provided before health care services have been provided to me by this individual, except in emergency cases, when my acknowledgement may be provided as soon after the emergency as is practicable. \_\_\_\_\_ (initials)

**Patient Consent for E-prescribing and Web Portal Invite:** I agree that CCHC may e-prescribe my prescriptions and may request and use my prescription medication history from their healthcare providers or third-party pharmacy benefit payers for treatment purposes. Additionally, if I provided an email address I understand CCHC will send me an invitation to join the web portal. \_\_\_\_\_ (initials)

**No Show Policy:** – A “no-show” refers to a patient who misses an appointment without cancelling/re-scheduling with at least 24-hour notice by phone, portal, text or in-person. To accommodate the significant number of individuals waiting for appointments, I acknowledge that if I “no show” to more than three (3) appointments in a 12-month period, I may not be allowed to make scheduled appointments and may have to come in on a walk in only basis for a six-month period. \_\_\_\_\_ (initials)

**Taking of pictures and/or recording of video/audio:** I consent to clinic photo, audio or video recording by CCHC and its medical, nursing and other professional staff members. I understand that the purposes of these photos are for identification, documentation processes of diagnosis and/or treatment. I acknowledge that these photo/audio/video recordings are used for the provision of care, quality improvement, education, and/or reimbursement purposes. \_\_\_\_\_ (initials)

**Authorization for Release of Medical Information:** Some patients prefer that other individuals, especially family members, be allowed access to their medical information. To comply with strict legal standards, a written release is required to allow another person access to your medical records. This release grants permission to individual(s) to make or confirm appointments, have access to x-ray and laboratory findings, pick up sample medications, be made aware of your diagnosis, prognosis, and treatment plans, and serve as your emergency contact. This permission applies to telephone and answering machine messages as well as other means of communication. \_\_\_\_\_ (initials)

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Legal Guardian Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Telephone:** ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

These consents will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not influence any actions taken prior to receiving the revocation.