Friendly Neighborhood Health Clinic

PATIENT REGISTRATION

Date: _____

Patient

Last Name _____ First Name _____ Initial _____

SS# _____ Date of Birth _____ Gender: ☐ Female ☐ Male

Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell) _____

Phone (Work) _____ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other _____

Preferred Language ☐ English ☐ Spanish

Have you been seen at another Clinic in the past 3 years? Yes☐ No ☐

Who is your current / past primary care provider? _____

Preferred Pharmacy_____ Major Crossroads _____

Health Insurance

Primary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Secondary Insurance _____

Policy Holder Name _____ Date of Birth_____

Employer _____ Relationship to Patient _____

HIPAA Information

To ensure compliance with current HIPAA guidelines, please provide us with the following information to establish your preferences for future confidential communications with our office.

Please indicate where you would like to be called to discuss your medical information:

☐ Home ☐ Work ☐ Cell *May we leave a message?* Yes No

Protected Health Care Information Designee:

☐ **I *do not*** want my health care information discussed with anyone other than myself.

☐ **I do** want my health care infomration discussed with individuals other than myself.

Please list those individuals with whom we may briefly discuss your medical information:

1) _____ Name _____ Phone Number _____ Relationship

2) _____ Name _____ Phone Number _____ Relationship

Authorizations

Your Signature below confirms your approval of your HIPAA communication preferences. You may change your information at any time, but must do so in writing by completing an updated form.

*I hereby give **consent for treatment of** my medic al problems to the health care provider of Friendly Neighborhood Health Clinic.*

Patients Signature **X** _____

Name_____ Date _____

Date of Birth _____

Friendly Neighborhood Health Clinic

Have you, your spouse, or a "blood" relative ever had the following	Yourself Yes	Yourself No	Relative Yes	Relative No	Relationship or Details	Doctor's Notes
Diabetes						
Thyroid problems						
Dizziness or fainting						
Heart Trouble or chest pain						
High blood pressure						
Asthma						
Hay fever or allergies						
Bowel / GI disorder						
Stomach ulcers						
Bleeding or blood disorder / Anemia						
Cancer						
Blindness or Glaucoma						
Deafness						
Neurologic disease(including Seizures)						
Stroke						
Depression						
Nervousness						
Mental retardation						

Arthritis or bone Disorder			Hospitalizations/Surgery	Year
Hepatitis or jaundice				
Injuries other than strains or sprains				
Major or prolonged illness				
Blood transfusion				

Do you smoke or use oral tobacco?
Yes____ How long? _____
No ____ Amount _____
If quit, how long?_____

Do you drink Alcohol?_____
Type _____Amount _____

Do you have a history of substance abuse?
Yes _____ No _____

Coffee / other caffeine?
Amount _____

Current Medications:
(Please list all)
_____
_____
_____
_____
_____
_____

Health Habits: Exercise _____
How Often: _____
Special Diet: _____

Do you have a medical power of attorney? ____
Who? _____

Vaccines:

Shingles: ____ Date:___/___
Pneumonia: _____ Date: ___/__

Flu: ____ Date:___/___
Tetanus: ____ Date: ___/____

COVID____ Date:____/_____
☐ Moderna ☐ Pfizer ☐ J&J

FOR WOMEN ONLY:

Age periods began _____
How long do they last _____
How many days apart are they _____
Menstrual problems _____
Date of Last Period___/____/____
Last Mammogram: ____/____
Last Bone Density: ____/_____

Number of pregnancies _____
Number of miscarriages _____
Number of children _____
Planning children? _____
Last pap smear _____
Last Colonoscopy _____

Drug allergies:
_____
_____
_____
_____

I have read and understood the following policies:

____ • **Narcotics Policy**
INITIAL

____ • **Acute & Chronic Pain Policy**
INITIAL

____ • **Financial Policy**
INITIAL

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE DATE