CALLEN LORDE COMMUNITY HEALTH CENTER

REGISTRATION FORM

#:_____

PATIENT INFORMATION

Legal last name: | Legal first: | Middle:

Today's date: / /

Social Security number: __ __

Chosen first name (if different):

Date of Birth: / /

Billing address:

Apartment #:

City: | State: | Zip Code:

Cell phone number: ( )

Home phone number: ( )

Work phone number: ( )

Which is your primary contact number?
- ☐ Cell
- ☐ Home
- ☐ Work

E-Mail Address for Patient Portal:
Must be 18 years of age or older

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ Ze ☐ A pronoun not listed ☐ No pronoun preference

We require the following information for the purposes of helping our staff use the most respectful language when addressing you, understanding our population better, and fulfilling our grant reporting requirements. The options for some of these questions were provided by our funders. Please help us serve you better by selecting the best answers to these questions. Thank You.

Preferred Spoken/Written Language:
- ☐ English ☐ Spanish
- ☐ American Sign Language
- ☐ Other: _____

Language interpretation services needed?
- ☐ No
- ☐ Yes, language: _____

Ethnicity:
- ☐ Non-Hispanic/Latino
- ☐ Dominican
- ☐ Cuban
- ☐ Mexican, Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino
- ☐ Decline to Answer

Migrant Worker?
- ☐ Yes
- ☐ No

Veteran?
- ☐ Yes
- ☐ No

Race: *Select all that apply*
- ☐ American Indian/Alaska Native
- ☐ Black and/or African American
- ☐ White/Caucasian

Asian:
- ☐ Asian Indian
- ☐ Chinese ☐ Korean
- ☐ Filipino ☐ Vietnamese
- ☐ Japanese ☐ Other

Native Hawaiian/Pacific Islander:
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Decline to Answer

Sexual Orientation — see Medical History Form
Gender Identity — see Medical History Form

Sex Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Intersex
- ☐ Decline to Answer

Housing Status:
- ☐ Stable Housing
- ☐ Homeless
- ☐ Decline to answer

If homeless, select which best applies:
- ☐ Street
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up (not paying rent)

How did you first learn of Callen-Lorde?
- ☐ Friend/Patient
- ☐ Referral
- ☐ Health Fair/Presentation
- ☐ Callen-Lorde Website/Internet
- ☐ Callen-Lorde Brochure/Ad
- ☐ Facebook/Social Media
- ☐ TV/Radio/Print Media

Do you have a non Callen-Lorde primary care provider that you want to continue to see?
☐ Yes ☐ No

Income

Anticipated annual household income for this year:

Total # of people living in household, including yourself:

Emergency Contact

Emergency contact name:

Emergency contact phone: ( )

INSURANCE INFORMATION

**Please give your insurance card to the front desk staff. **

If you do not have health insurance, please complete the Application for Sliding Discount to apply for a sliding scale discount based on your income.

Insurance carrier: | Policy #: | Group #:

Sex listed in insured's health insurance plan: ☐ Male ☐ Female

Insured's birth date: / /

Name of insured (if different):

Address of insured: ☐ Same as Patient

I verify that the above information is correct to the best of my knowledge.

X _____ **Patient Signature**

_____ / / _____ **Date**

MR#:_____

CALLEN-LORDE COMMUNITY HEALTH CENTER
PATIENT CONSENT FORM

ALL PATIENTS: PLEASE READ AND SIGN AT #1 AND #2 PRIOR TO FIRST VISIT

1) CONSENT FOR TREATMENT:

I, _____ (**please print name**) am voluntarily seeking medical care and treatment from Callen-Lorde Community Health Center ("Callen-Lorde") and give permission to the medical, mental, and oral health staff of Callen-Lorde to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

X_____ ____/____/____
Patient Signature ***Date***

2) CONSENT TO BILL:

√ If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Callen-Lorde's Patient Financial Policy;

√ If my insurance is accepted, I authorize payment of benefits to Callen-Lorde or will reimburse Callen-Lorde if I am paid directly by my carrier;

√ I hereby authorize that Callen-Lorde may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;

√ I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;

√ I understand that my insurance may not cover all charges deemed medically necessary by Callen-Lorde;

√ I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

X_____ ____/____/____
Patient Signature ***Date***

3) Patient Rights and Responsibilities:

√ I have received a copy of the Callen-Lorde Patient Rights and Patient Responsibilities

X_____ ____/____/____
Patient Signature ***Date***

CALLEN LORDE
COMMUNITY HEALTH CENTER

MRN:_____

ACKNOWLEDGMENT OF RECEIPT OF
HIPAA NOTICE PRIVACY PRACTICES

I acknowledge that I have received a copy of the Callen-Lorde **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Personal Representative Name (Please Print)

_____ _____
Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please note: It is your right to refuse to sign this Acknowledgment

----------*Staff Use Only*----------

I tried to obtain written Acknowledgement by the noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgment.
__ A communication barrier prevented us from obtaining acknowledgement.
__ The individual was unwilling to sign.
__ Other: _____

_____ _____ _____
Staff Member Name (Please Print) Staff Member Signature Date

CALLEN LORDE COMMUNITY HEALTH CENTER

MEDICAL HISTORY FORM

#:_____

PATIENT INFORMATION

Last name:	First:	Date of Birth: / /

Lifestyle

Alcohol: Do you drink alcohol?

☐ Yes ☐ No, I used to drink. ☐ No, I quit drinking _____ years ago.

If yes or used to drink:

Type: _____ How often? _____ Amount: _____

Type: _____ How often? _____ Amount: _____

Housing: What is your housing status?

☐ Stable housing ☐ Homeless

If homeless:

☐ Street ☐ Transitional

☐ Shelter ☐ Doubling Up

Exercise: Do you exercise? ☐ Yes ☐ No

Type: _____ How many hours a week? _____

Type: _____ How many hours a week? _____

Sleep Patterns:

Do you have any changes in your sleep patterns?

☐ Yes ☐ No

Advance Directives

Do you have any of the following advance directives?

☐ Living will ☐ None

☐ Power of attorney ☐ Prefer not to answer

☐ Health care proxy

Sexual Orientation

☐ Gay ☐ Lesbian ☐ Bisexual ☐ Queer ☐ Straight ☐ Something Else ☐ Decline to Answer

Gender Identity

☐ Male/Man ☐ Female/Woman ☐ TransMale/Transman ☐ TransFemale/Transwoman ☐ Genderqueer/Nonconforming ☐ Something Else ☐ Decline to Answer

Confidential Information

Sexual Practices:

Are you sexually active?

☐ No ☐ Yes ☐ Previously

If yes or Previously:

Anal-receptive with	☐ Male	☐ Female	☐ Both	Oral-receptive with	☐ Male	☐ Female	☐ Both
Anal-insertive with	☐ Male	☐ Female	☐ Both	Oral-insertive with	☐ Male	☐ Female	☐ Both
Vaginal-receptive with	☐ Male	☐ Female	☐ Both	Oral-anal with	☐ Male	☐ Female	☐ Both

Drug Use/Abuse:

Do you use or abuse drugs?

☐ No ☐ Yes ☐ Previously

If yes or Previously:

Type: _____ Frequency: _____ Route: _____ ☐ I quit on date: _____

Type: _____ Frequency: _____ Route: _____ ☐ I quit on date: _____

Medical History

Do you have now or have you had any of the following conditions?

Date of Last Dental Exam: _____

☐ Abnormal Pap	Date:	☐ Deep Venous Thrombosis	Date:	☐ HPV	Date:
☐ Anemia	Date:	☐ Depression	Date:	☐ Heart Disease	Date:
☐ Arthritis	Date:	☐ Diabetes Type: ____	Date:	☐ Obesity	Date:
☐ Asthma	Date:	☐ Kidney Disease	Date:	☐ Seizure disorder	Date:
☐ Breast mass	Date:	☐ Gonorrhea	Date:	☐ Syphilis	Date:
☐ Cancer: _____	Date:	☐ Hepatitis Type: ____	Date:	☐ Tuberculosis	Date:
☐ Chlamydia	Date:	☐ High cholesterol	Date:	☐ Other : _____	
☐ Cirrhosis of liver	Date:	☐ HIV	Date:		

Surgical History

Please check off any surgeries you have had.

☐ Angioplasty	Date:	☐ Cardiac Pacemaker	Date:	☐ Hernia Repair, Inguinal	Date:
☐ Appendectomy	Date:	☐ Cholecystectomy	Date:	☐ Hysterectomy, total, BSO	Date:
☐ Augmentation Mammoplasty	Date:	☐ Dialysis, renal	Date:	☐ Mastectomy	Date:
☐ Biopsy: _____	Date:	☐ Gender Confirming	Date:	☐ Thyroidectomy	Date:
☐ CABG	Date:	☐ Hemorrhoidectomy	Date:	☐ Tonsillectomy	Date:

☐ Other: _____

Family Medical History

☐ Family Medical History Unknown ☐ Adopted - no family history known

				Unknown
Father:	☐ Alive	☐ Deceased (Age: _____)	Medical Condition(s): _____	☐
Mother:	☐ Alive	☐ Deceased (Age: _____)	Medical Condition(s): _____	☐
Sister:	☐ Alive	☐ Deceased (Age: _____)	Medical Condition(s): _____	☐
Brother :	☐ Alive	☐ Deceased (Age: _____)	Medical Condition(s): _____	☐