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**Patient Registration Form**

**2020**

**PATIENT INFORMATION:**

Name:  Middle Initial:

*(LAST/SURNAME) ( FIRST NAME)*

Date of Birth: // Age: 

(MONTH) ( DAY) (YEAR)

 **New Patients**  **Returning Patients\***   
\*Returning patients - If your health history has not changed, please skip the health history portion of this form (Pages 7-9)

Gender:  Male  Female  Transgender: Male to Female  Transgender: Female to Male  Gender Nonconforming

 Other gender identity not listed above:   Prefer not to answer

Address: County: 

City:  State: Zip: 

Language(s):  Interpreter Needed: No  Yes

Marital Status:  Single  Married  Separated  Divorced  Widowed Veteran:  Yes  No

**Race/Ethnicity:**

 African

 African-American/Black

 Asian

 Native Hawaiian/Pacific Islander

 Caucasian

 Latino/Hispanic

 American Indian/

Alaska Native

 Arab/Middle Eastern

 Multiracial

 Unknown

 Multiracial

**CONTACT INFORMATION:**

Phone(Primary):  Cell  Home Other:

Phone(Secondary):  Cell  Home Other:

***We may need to contact you. Please check all that we have your permission to leave messages on or with:***

Voicemail/Texting

Check here to opt out of receiving text messages

SPECIFIC Person ONLY, provide the name(s): 

**Please list an EMERGENCY contact below:**

, , 

**(FULL NAME) (PHONE) (RELATIONSHIP)**

Please list any **hospitalizations, surgeries, or ER visits** you have had.

1.  Date: 

2.  Date: 

3.  Date: 

4. Date: 

**MEDICAL/DENTAL RECORDS:**

 Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name:

Address: 

Phone: Fax: 

 Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name: 

Address: 

Phone: Fax: 

 Dental  Medical  Mental Health Counseling  Current  Previous

Clinic/Provider Name: 

Address: 

Phone: Fax: 

Do you have dental, medical, or mental health counseling records that you would like to have sent to us from past or current clinics?

 *No*  *Yes (Please ask reception for a Release of Information form and we will request the records)*

**INSURANCE INFORMATION:**

**HEALTH:**

Do you have any forms of health insurance right now?  No  Yes

**If yes**, please identify the type of coverage you have below and *provide a copy of your card to reception*. Common types are (*Medicaid/Apple Health, Medicare, Veteran Benefits, or contracted from the Health Exchange*)

**Insurance Plan:**  **Yearly Deductible: $**

**If no**, have you ever applied for Health insurance?  No  Yes Date Applied: 

*(If you applied and were denied coverage, please provide a copy of denial letter to reception.)*

**DENTAL:**

Do you have any dental insurance?  No  Yes

**If yes,** please identify what type of insurance you have and provide a copy of your card to reception (Medicaid/Apple Health, Delta Dental, etc.)

**Dental Insurance:** 

|  |
| --- |
| **Country of Birth:**  **Are you a visitor?**  Yes  No  **If Yes**: What is the date of arrival:  Date of Departure:  Reason for visit (Refugee/Asylee, Family, Type of Visa, etc):  (If you are applying for asylum, please provide a copy of Asylum application to reception) |

**HOUSEHOLD INFORMATION:**

*Your annual income and your family size are necessary to determine your eligibility. Your answers will be kept on file and in strict confidence.*

***Please choose 1 from the list below to verify your income:***

1. *Income tax return from the previous year*
2. *A copy of your W-2 form*
3. *Two months of paycheck stubs*
4. *Two months of bank statements*
5. *Copies of your social security checks or letter, or other checks you may receive.*

***You must verify your income every year. Please bring a copy to your appointment.***

|  |  |
| --- | --- |
| **Are you employed?** No  Yes | **Patient’s Monthly Employment Income:** |
| **Is your spouse/partner employed?**  N/A  No  Yes | **Spouse/Partner’s Monthly Employment Income:** |
| **How many people are supported with the total household income?** | |

Does anyone else in your household have any form of income that supports you (spouse, parent, etc.)? If so, please fill out the following:

|  |  |
| --- | --- |
| **Other Income** | |
| Social Security: | $ |
| Food Stamps: | $ |
| Public Assistance: | $ |
| Retirement Pension: | $ |
| Child Support, Alimony: | $ |
| Other: | $ |
| **TOTAL:** | $ |

***I do hereby swear or affirm that the information provided above is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for programs at Lahai Health. I further agree to inform Lahai Health if there is a significant change in my income. If acceptance to the Lahai Health programs is obtained under this application, I will comply with all rules and regulations of Lahai Health. I hereby acknowledge that I read the foregoing disclosure and understand it.***

Patient Digital Signature:  Date: 

**PATIENT PRIVACY AGREEMENT**

This notice describes how your medical and personal information may be used and disclosed at Lahai Health. Your protected private information includes personal and demographic information such as your name, address, date of birth, various identification numbers and phone numbers. It also includes all health information relating to your past, present, and future physical or mental health conditions.

We use and disclose your private information in many ways when providing you with care. If our healthcare providers ask you to see a specialist, we may disclose your name and reason for referral to the specialist. If a pharmacy calls us with a refill request, we may confirm your information with them. When we send a specimen to the laboratory, we disclose your name and other demographic information to them. This type of disclosure between our healthcare providers and other care providers is necessary to provide you with the best and most effective care. Your primary health care team may include, but is not limited to: providers, nurses, dietitians, spiritual care & physical therapists.

There are situations where we may release your information without your expressed consent. These situations include but are not limited to: emergencies, required reporting to public health entities, and as required by law enforcement agencies. You may have rights regarding our use of your private information. You have the right to limit disclosure (in writing) of your information. You have the right to know if we disclose your information for non-routine health care purposes. You have the right to see your medical records and request amendments or corrections. This notice will be kept on file. You may file a complaint regarding the disclosure of your information to our Clinic Director.

***I have read and understand the agreement above between Lahai Health and myself regarding the privacy of my information. This agreement will remain in effect until it is revoked in writing by the undersigned.***

Patient Digital Signature:  Date: 

**CONSENT FOR DENTAL, MEDICAL or COUNSELING TREATMENT**

Choose all that apply:  Dental  Medical  Mental Health Counseling

In order to receive quality care, I authorize the release of my medical, dental or mental health counseling information to Lahai Health in order to provide me with care. I authorize Lahai Health to release my medical records to other health care providing agencies for the purpose and benefit of providing health care to me.

I hereby give consent to receive medical, dental or counseling care from Lahai Health and its providers and healthcare staff. If patient is a minor, the patient’s parent/guardian must consent to care and treatment. I understand that there are exceptions when care can be obtained by a minor without parental or guardian consent, based on Washington State law and Federal law.

The information provided on my intake paperwork is accurate to the best of my knowledge and I will inform Lahai Health of any changes in my health, medications, health insurance status, income or contact information.

Privacy Practices are listed above in the “Patient Privacy Agreement”. I understand that I can obtain a personal copy, upon request.

***This authorization will remain in effect for any care received through Lahai Health until it is revoked in writing by the undersigned.***

**Patient Digital Signature:**  **Date:** 

**LAHAI HEALTH MISSED APPOINTMENT POLICY**

It is important that Lahai Health patients keep their appointments. When a patient doesn’t show up for a scheduled appointment, cancels last minute, or arrives late, the clinic’s *very* *limited resources* are wasted when Lahai Health could have served another patient in need of care.

**Rescheduling Appointments**

To reschedule, please call Lahai Health (206-363-4105 MEDICAL: Ext 230, DENTAL: Ext 701, COUNSELING: Ext 231) as soon as you know that you will not be able to keep the appointment, ***at least 24 hours prior to your appointment time***. Please leave a message on the scheduling line if your call is not answered.

**Missed Appointments**

If you miss a scheduled appointment completely, cancel with less than 24 hours’ notice, or arrive more than 10 minutes late, this will be recorded in your electronic chart. **Please note if you arrive late, you may have to be rescheduled, if there is not enough time to complete your visit or procedure.**

If you have **2 missed appointments** (includes late cancels or late shows) within a 1-year time frame, you will not be able to schedule with Lahai Health for a period of 6 months. You will receive a letter from clinic staff notifying you of the date you may return for care.

***I understand the Lahai Health Missed Appointment Policy and agree to follow the terms of this policy.***

**Patient Digital Signature:**  **Date:** 

**---------------------------------------------------------------------------------------------------**

**RECEPTION USE ONLY:**

Clinic Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy of Identification (ID) provided (*indicate type*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Documents provided (*indicate type*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy of Insurance Cards provided (*only for patients with any insurance*)

Explanation of Financial Standing form completed (*if applicable*)

ROI for dental/medical records completed (*if needed*)

Signed medical interpreter form (if applicable indicate type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed Text Messaging(SMS) consent (if applicable)

Specify what percentage patient falls under the Federal Poverty Level

(*Refer to the FPL chart*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_%

**SOCIAL HISTORY:**

Where are you currently living?  House  Apartment Car  Homeless/Unstable Housing  Other: 

Do you feel safe in your current relationship?  No  Yes

Sexual Orientation:  Heterosexual  Homosexual Bisexual  I prefer not to answer.

Number of Lifetime Sexual Partners:  Number of Sexual Partners in the Last Year: 

Use of Caffeine (Coffee/Tea/Soda):  Never  Rarely  Moderate Daily Previously, but I quit.

Use of Alcohol:  Never  Rarely  Moderate  Daily  Previously, but I quit.

Use of Tobacco:  Never  Rarely  Moderate  Daily  Previously, but I quit.

Use of Marijuana:  Never  Rarely  Moderate  Daily  Previously, but I quit.

Use of Recreational Drugs:  Never  Rarely  Moderate  Daily  Previously, but I quit.

Exercise:  Never  Rarely  Moderate  Daily, Types of Exercise: 

**SPIRITUAL CARE:**

Would you like for someone to pray with/for you or help with faith-based questions?  Yes  No

Do you have other concerns? (For example: Housing, food stamps. Financial assistance, or transportation):  Yes  No

**If you answered yes to any of the above**, please ask receptionist to speak with the patient advocate.

(**Dental:** please ask receptionist.)

\*\*\*How did you hear about Lahai Health?  Online  Goodwill Screening  Church: 

 Lahai Health Volunteer  Family/Friends  Other:

**CURRENT MEDICATIONS:**

Please list all medications (prescriptions, over the counter, vitamins and supplements). For additional medications, please attach separate sheet.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication:** | **Dosage: (mg/ml)** | **Frequency:** | **Date Started:** | **Prescribed By:** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***Please indicate your preferred pharmacy:***

Pharmacy: 

Address: 

Phone:  Fax: 

**MEDICAL INFORMATION:**

Please indicate any medical problems YOU have experienced and indicate the date/year.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Medical Problem** | **Date** | **Medical Problem** | **Date** | **Medical Problem** |
|  | Alcohol/Drug Problem |  | Osteoporosis |  | Liver Problem |
|  | Allergies/Hay Fever |  | Diabetes |  | Seizures |
|  | Arthritis |  | Depression or Suicide Attempt |  | Mental Health (Bipolar, Schizophrenia, etc.) |
|  | Asthma/Emphysema |  | Glaucoma |  | Stroke |
|  | Bladder or Kidney Infections, Kidney Stones |  | Heart Disease or Heart Attack |  | Sexually Transmitted Disease |
|  | Bleeding/Clotting |  | High Blood Pressure |  | Thyroid Condition |
|  | Cancer (specify below) |  | High Cholesterol |  | Tuberculosis |

**FAMILY MEDICAL HISTORY:**

Please indicate anyone in your FAMILY who has or had the conditions below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Alcohol/Drug |  | Cancer (type) |  | Mental Illness |  |
| Allergies |  | Cholesterol |  | Migraines |  |
| Alzheimer |  | Depression |  | Nerve Disorder |  |
| Arthritis |  | Diabetes |  | Obesity |  |
| Asthma |  | Eye/Ear Problem |  | Lung Problem |  |
| Blood Disease |  | Genetic Disorder |  | Sickle Cell |  |
| Bladder/Kidney |  | Stomach/Intestine |  | Stroke |  |
| Blood Pressure |  | Heart |  | Thyroid |  |

**ALLERGIES**

I have no allergies. Yes, I have allergies. (***If yes****, please list allergy and reaction below*.)

1. , 

**(ALLERGY) (REACTION)**

2. , 

**(ALLERGY) (REACTION)**

3. , ­

**(ALLERGY) (REACTION)**

**PAST MEDICAL:**

**Last visit to a doctor/provider:** 

**Last visit to a dentist:** 

**Last Complete Physical:** 

**Eye exam/Glaucoma Check:** 

**Tetanus Vaccine:** 

**Women ONLY:**

**Last PAP smear:** 

**Abnormal PAP History?**  **No**  **Yes**

**Last Mammogram:** 

**# of Pregnancies:** 

**Miscarriages/Abortions?**  **No**  **Yes**

**Age at Menopause:** 

***Please list any current Medical Diagnoses:***

1.  Date Diagnosed: 
2.  Date Diagnosed: 
3.  Date Diagnosed: 

**CURRENT SYMPTOMS:**  Please check all boxes that apply to you.

**CONSTITUTIONAL SYMPTOMS:**

 Unexplained weight loss or gain

 Fever or chills

 Night sweats/hot flashes

 Fatigue

**HEMATOLOGICAL/LYMPHATIC**

 Bleeding or bruising tendency

 Swollen glands

**EYES/EARS/NOSE/THROAT**

 Changes in vision

 Hearing loss or ringing

 Ear aches or drainage

 Chronic sinus problems or Hay Fever

 Recurrent nose bleeds

 Bleeding gum

 Sore throat or voice change or

hoarseness

**RESPIRATORY**

 Chronic, frequent coughs

 Shortness of breath

 Asthma or wheezing

 Tuberculosis, positive TB skin test

 Spitting up blood

**CCARDIOVASCULAR**

 Heart trouble/heart murmur

 High blood pressure

 Chest pain or angina pectoris

 Palpitations (fast or irregular heartbeat

 Shortness of breath in walking/lying flat

 Swelling of feet, ankle or hands

 Swelling of feet, ankle or hands  
  Rheumatic fever

**NEUROLOGICAL:** Frequent or recurring headaches

 Light headed or dizzy

 Convulsions or seizures

 Numbness or tingling sensations

 Paralysis

 Memory loss or confusion

 Nervousness  
  Insomnia

**ENDOCRINE**

 Thyroid disease

 Diabetes, excessive thirst or   
 urination

 Other grandular or hormone

problem

**URINARY**

 Frequent urination

 Burning or painful urination

 Blood in urine

 Incontinence or dribbling

 Sexual difficulty

 Kidney or bladder infections

**GASTROINTESTINAL**

 Loss of appetite

 Change in bowel movements

 Nausea or vomiting

 Diarrhea

 Painful bowel movements or

constipation

 Regular laxative use

 Rectal bleeding or blood in stool

 Black colored stools

 Hemorrhoids

 Abdominal pain or heartburn

 Trouble swallowing

**MUSCULOSKELETAL**

 Arthritis

 Joint pain

 Joint stiffness or swelling

 Back pain

Fractures

**INTEGUMENTARY**

 Rash or itching

 Abnormal hair loss

 Breast pain

 Breast lump

Breast discharge

**MALE:**

 Discharge from penis, sores on genitals

 Decrease in urine stream

 Dribbling

 Slow to start/stop urination

 Urination at night (more than 1x/night)

 Erectile dysfunction

**FEMALE:**

 Date of last menstrual period: 

 Birth control issues/questions

 Pain with intercourse

 Vaginal discharge/itching

 Do you have hot flashes?

 Are you taking hormones?

 Do you take calcium?

**EMOTIONAL/MENTAL HEALTH:**

 Depression

 Anxiety

 Panic

 Thoughts of suicide

 Other: 

**OTHER:**

 Tropical illness, travel outside the US

Disability (any

***Other issues/symptoms you want discuss with the medical provider:***



**\*PROVIDERS ONLY: As a provider, I have reviewed pages 6, 7, and 8 of this patient’s intake form.**

Provider’s Printed Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Provider’s Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**