BAY ..LLS HEALTH CENTER PATIENT CONSE. ·FORM

PATIENT REGISTRATION AND FAMILY INFORMATION Chart #_______________

Patient Name____
(First) (Middle Init) (Last)

Maiden Name:__________________Date of Birth:______________Age:____ Gender:________ Marital Status:________________

Mailing Address:________________________________ City/State/Zip____________________ Date moved to area:__________

Social Security Number____________ Home Telephone:__________Cell Phone:__________ Access to Internet ___Yes___No

Email address______________ Preferred Method on Contact:_________ OK to leave message ___Yes___No

Are You a Veteran? ___Yes ___No If yes, Branch_________ Vietnam Connected? ___Yes ____No Service entry date:_____Service exit date:________

Are you a migrant worker ____Yes ____No Are you homeless ____Yes ____No

Race (circle one): Native American -Tribal affiliation_____________ (proof required) Caucasion Black/African American Unknown Decline

Ethnicity (circle one): Decline Hispanic/Latino Non Hispanic/Latino Unknown Other______________________

Primary language_____________Interpretor required ____Yes _____No Patient's Employer____________________

Household Income: Information collected will be kept confidential. It is required we collect this information in order to receive federal funding. Circle one:
$0.00-$23,050 $23,051-$34,475 $34,575-$46,100 More than $46,101 ____#in household

Emergency Contact:________________________Relationship to patient:________________________Phone:__________

Parent, Spouse, nearest relative or Guardian:____________________Relationship to patient:__________ Phone:__________

OFFICE STAFF WILL PHOTOCOPY YOUR INSURANCE CARDS AND DRIVERS LICENSE

INSURANCE POLICY HOLDER INFORMATION

1st Insurance Co. (Primary):____________________

Contract # _______________Group#________

Policy Holder Name:____________________

Policy Holder's Date of Birth:________________

Relationship to Patient:________________

Policy Holder's Employer:________________

Secondary Ins/Dental/Other

Insurance Co.:____________________________

Contract#______________ Group #__________

Policy Holder Name:________________________

Policy Holder's Date of Birth:________________

Relationship to Patient:____________________

Policy Holder's Employer:____________________

AGREEMENT FOR EXAMINATION AND/OR TREATMENT

I hereby and voluntarily agree and consent to be examined and treated by my provider at Bay Mills Health Center. I understand I have the right to participate in decisions involving my health care. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize release of any and all clinic medical records relevant to my examination and/or treatment, to (a) the consulting and/or referring physician or agency or (b) the source(s) of continuing care, including but not limited to practitioners of Bay Mills Medical Center staff. I also authorize the release of these records for any payment or quality management related purpose to any (a)insurance carrier, (b)government agency or unit, or (c) any third party payer in any way involved in the payment for all or any part of my health care.

Optional I, give Bay Mills Health Center, permission to speak with the following people regarding my medical and/or financial information. This authorization is valid until such time as I provide BMHC written revocation of it

______________________________ ____________________Please circle Financial Medical

Name and Phone Number Relationship to patient

FINANCIAL RESPONSIBILITY

I have received a copy of the Patient Bill of Rights and Patient Responsibility statements as they relate to Bay Mills Health Center. I understand that I remain financially responsible to Bay Mills Health Center for all charges incurred for services rendered. Bay Mills Health Center will bill any applicable insurance for payment of services. Any balance remaining is my responsibility and I will make consistent and timely payments until the balance is paid in full. **Person Responsible for payment:**____________________________Relationship:____________________________________

NATIVE AMERICAN DIRECT CARE SERVICE AND SLIDING FEE RECIPIENTS

I understand that services performed by the BAY MILLS HEALTH CENTER as a Native American Direct Care Service or Sliding Fee charge are only as a last resort for payment. If I receive any monies that are related to or are a reimbursement for services, I am responsible for paying the amount that was reimbursed for that service to the Bay Mills Health Center. This obligation is acknowledged for any clinic visit and Sliding Fee prescriptions that have been paid on my behalf.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The Notice of Privacy Practices for Bay Mills Health Center has been made available to me for my review. I understand that I may request a copy of the notice at any time.

____________________________________ ____________________________________

Patient/Representative Signature Date

PATIENT RIGHTS AND RESPONSIBILITIES (Offer Annually)

_____ **PATIENT'S RIGHTS AND RESPONSIBILITIES** have been made available to me and I have read and understand these rights and responsibilities.

Pt Init.

_____ I have declined a copy of the **PATIENT'S RIGHTS AND RESPONSIBILITIES** and am aware that they are available to me or request in the future.

Pt Init.

ADVANCE DIRECTIVES (Offer Annually)

Does the patient have written Advance Directive: ___Yes ____No

Is a copy on file in chart? _____Yes ______No

Date:______________________________

Does the patient have a Power of Attorney: ___Yes ____No

Is a copy on file in chart? _____Yes ______No

Date:______________________________

I HAVE READ THIS CONSENT FORM AND I AM FULLY AWARE OF AND AGREE TO THE CONTENTS. ***THIS FORM IS VALID FOR ONE YEAR FROM THE DATE OF THE MOST RECENT SIGNATURE.***

____ __________________________________

Insured/Patient/Guardian (if minor or incompetent)/Guarantor Dated | Witness Dated

____ __________________________________

Insured/Patient/Guardian (if minor or incompetent)/Guarantor Dated | Witness Dated

____ __________________________________

Insured/Patient/Guardian (if minor or incompetent)/Guarantor Dated | Witness Dated

HEALTH HISTORY

Name: ______________________________ DOB __________ Date __________

Describe Any Allergies and Type of Reaction to Medications: ____________
____

Past Health History

___ Arthritis
___ Ulcers
___ Tuberculosis
___ Asthma/Emphysema
___ Diabetes
___ Heart Murmur
___ High Blood Pressure
___ Alcoholism
___ Anemia
___ Unexplained Weight Loss
___ Epilepsy/Seizures

Other Serious Injuries/Illnesses: ____
____

Hospitalizations and Operations

Month and Year	Type/Reason for Hospitalization	Name and Place of Hospital

Have you had a Blood Transfusion? ______________________________

List Any Medication or Drugs you're Currently Taking

Medication	How Often	Reason	Who Prescribed Med.

Please Give the Year You Last had the Following Test/Immunization:

Year	Test	Year	Test
	Physical		Tetanus/Diphtheria
	Tuberculosis Skin Test		Flu Shot
	Chest X Ray		Hearing Test
	Dental Check Up/Exam		Vision Test
	Electrocardiogram (EKG)		

Please Complete the Reverse Side

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

For Men Only:

___ Sores on Penis ___ Discharge from Penis ___ Herpes
___ Venereal Warts ___Pain or Burning with urination
___ Contraception Method: ________________________________

For Women Only:

___Venereal Warts ___ Pain/Burning with urination ___Herpes
Date of your Last Menstrual Period: ______________ Was it normal for you? ______
Date of Last Pap Smear: ______________ Have you had an Abnormal Pap? ________
Date of Last Breast Exam: ________________ Mammogram: ________________
Method of Birth Control: ________________________________
Number of Pregnancies: ____ Miscarriages: _____ Stillborn: _____ Abortions: _____
Number of Living Children: ____________________

Family History:

PLEASE CHECK IF ANYONE IN YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING:

___ Tuberculosis ___ Bleeding Problems ___ Diabetes
___ Asthma/Emphysema ___ Cancer ___ Committed Suicide
___ Stroke ___ High Blood Pressure ___ Alcoholism
___ Mental Illness ___ Kidney Disease or Stones ___ Heart Attack

Other Conditions/Illnesses in your Family: ________________________________
____
____

Social History:

Do you smoke cigarettes? _________ If yes, how much per day? ____________
For how many years? _______________
Do you consume alcoholic beverages? ________ Estimated quantity per day__________
Have you ever used IV drugs? __________ What type of drug? ______________

Stress:

Please check any of the following if they have occurred in your life in the past 20 years:

___ Death of a spouse or close friend ___Legal Problems ___Housing Problems
___Separation or Divorce ___Loss of a Job ___Suicide Attempt
___Mental Health or Counseling ___Unemployed How long? ______________
___Jail Term/Jail Time

How do you handle your anger? ________________________________
____

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