MOUNTAIN HEALTH CARES

Patient Chart Number_____Registered by_____Date_____

PATIENT INFORMATION

Last Name: _____First Name: _____ MI: ____
Home Phone: (_____) _____ Cell Phone: (_____) _____
Mailing Address: _____
Physical Address (if PO Box is provided): _____
City: _____ State: _____ Zip Code: _____
Sex: ___Male ___Female Birthdate: _____ Age: _____
Social Security#: _____ Email Address: _____
Maiden Name: _____ Place of Birth: _____ Mother's First Name: _____

Patient Initial:_____ By initialing, I approve MHCS to leave messages on my answering machine and/or voicemail.
Patient Initial:_____ By initialing, I am declining MHCS to add me to the mailing list for uses and disclosures of PHI (Protected Health Information) for marketing purposes.

Marital Status (check one): _____ Single _____ Married _____ Widowed
_____ Divorced ____ Legally Separated

Ethnicity: Hispanic or Latino: ___ Yes ___ No **Patient a Veteran:** ___ Yes ___ No

Race (circle all that applies): African American Asian Other Pacific Islander
Native American/Alaska Native Native Hawaiian White
Unknown Decline to State

Communication Requirements: **Interpreter Needed:** ___ Yes ___ No
Hearing Impaired: ___ Yes ___ No
Legally Blind: ___ Yes ___ No

How did you hear about us: ____ Advertising _____ Outreach/Event ____ Website
____ Internet Search ____ Referral from Friend or Patient
_____ Insurance Plan ____ Other

PROVIDER INFORMATION

Dentist Name: _____ Phone: _____
Specialist Name: _____ Phone: _____

EMERGENCY CONTACT INFORMATION (Must be at least 18 years of age)

Last Name: _____ First Name: _____ MI: _____
Phone: (Home) _____ (Work) _____ (Cell) _____
Relationship to Patient: _____

Mountain Health

INSURANCE INFORMATION
PRIMARY Insurance Company Name: _____
SECONDARY Insurance Company Name: _____

HEAD OF HOUSEHOULD (BILL TO)
Last Name: _____First Name: _____ MI: ___
Date of Birth: _____ Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Mountain Health is a federal qualified Health Center, 501(c) 3, non-profit agency. Our fees reflect our cost. In order to provide you with low cost medical care, payment is expected at time of service.

EMPLOYMENT STATUS
___Employed: (F/T **or** P/T) ____ Self Employed ____Unemployed ____Student: (F/T **or** P/T)

Patient's Employer_____ Work Phone: (____) _____
Source of Income: __ Employment __Unemployed ___Disability ___Retirement __Other
Type of Employment: ___Management ___Production ___Sales/Service
___Farming ___ Migrant
Monthly Gross Income: $_____ Family Size: _____

EDUCATION
Circle Patient's Highest Level of Education:
Elementary: None K 1 2 3 4 5 6 Junior High: 7 8
High School: 9 10 11 12 College: 13 14 15 16 Vocational School Other

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the above. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health care status or the above information.

I assign all medical and/or surgical benefits to which I am entitled, including Medicare benefits, to MOUNTAIN HEALTH & COMMUNITY SERVICES, not to exceed the total of valid charges. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that certain services may be considered **non-covered or not medically necessary** by my insurance carrier(s) and that coverage may be denied. I understand that I am responsible for payment of these services. I authorize the release of any medical or other information to process claims to secure payment form insurance carrier and/or Medicare.

Signature Date

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

CONSENT FOR TREATMENT

The undersigned patient and/or responsible relative or person hereby authorizes MOUNTAIN HEALTH and its assigned physician and ancillary personnel to administer and perform any and all medical examinations, treatment, diagnostic and surgical procedures, Behavioral Health Services or other services which may now or during the course of the patients care be deemed advisable or necessary.

I understand that ancillary personnel include Nurse Practitioners, Physician Assistants, Nurses, Medical Assistants and Billing Clerks.

It is further understood that if the patient or responsible party on behalf of the patient refuse any treatment suggested, I automatically release the clinic/office from responsibility for damages, which may occur, because of my refusal. Refusal of treatment will be documented and witnessed by not less than two (2) persons, including the treating Physician.

____

Print Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

Please provide us with names of individuals with whom we may discuss your care, provide paper work on your behalf, and who can pick up prescriptions for you. Thank you.

Name:______________________________Relationship:_________________Phone#:____________
☐ Check this box, if the person listed above can also discuss your Behavioral Health care.
☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________
☐ Check this box, if the person listed above can also discuss your Behavioral Health care.
☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________
☐ Check this box, if the person listed above can also discuss your Behavioral Health care.
☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

Name:______________________________Relationship:__________________Phone#:____________
☐ Check this box, if the person listed above can also discuss your Behavioral Health care.
☐ Check this box, if the person listed above can also discuss your Reproductive Health care.

____

Signature of Witness Date

Patient Name: _______________________________DOB: _____________ Medical Record #: __________

Mountain Health

CONSENT FOR HEALTH INFORMATION EXCHANGE

A Health Information Exchange (HIE) is a way of sharing your health information among participating doctors' offices, hospitals, labs, clinics and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and other health care professionals will not be able to search for your health information through the HIE to use while treating you. However, you may choose to allow participating providers to access your information through the HIE in the event of a medical emergency. Public health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE.

☐ Check this box to Opt-In ☐ Check this box to Opt-Out except in a Medical Emergency
☐ Check this box to Opt-Out Completely (EVEN in a Medical Emergency)

_____

Print Name of Patient/Responsible Party Signature of Patient/Responsible Party Date

_____

Signature of Witness Date

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

HIPAA CONSENT

I_____ acknowledge that I have reviewed and understand the following Mountain Health & Community Services, Inc. (Mountain Health) regarding my rights and responsibilities:

1. I understand my Patient Rights and Responsibilities which are posted in the waiting room. I also understand that I may request a copy of the Patient Rights and Responsibilities from the receptionist.
2. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
   - Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
   - Obtain payment from third party payers.
   - Conduct normal healthcare operations such as quality assessments and physician certifications.
   - I acknowledge that I have received a copy of Mountain Health Privacy Practices containing a more complete description of the uses and disclosures of my health information, and I consent to the use of my Protected Health Information (PHI) for treatment, payment, and healthcare operations of the practice.
   - I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.
   - I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.
3. I understand that all co-pays are due at the time of services. In the event, I cannot pay my co-pay at the time of service. ***I will be billed my co-pay and an additional $10.00 processing fee.***
4. I understand and acknowledge that I have ability to receive or decline Advance Directives offered by the front desk receptionist at my initial visit and at any time I have access to change my Advance Directives by speaking with the receptionist at the front desk.

_____ _____ _____

Patient Name Signature Date

If you would like a copy of Patient Rights and Responsibilities, HIPAA Privacy Notice and/or Advance Directives, please request copies from the receptionist.

FOR OFFICE USE ONLY:
I attempted to obtain the patient's signature regarding Mountain Health's Patient Rights and Responsibilities, HIPAA Privacy Notice and/or Advance Directives Acknowledgement and, $10.00 co-pay processing fee, but was unable to do so as documents below:

_____ _____

Date Staff Member Signature

Reason:_____

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

MEDICAL HISTORY

Please answer the following:

Name:_____

Do you have now or have you ever had the following:

	Yes	No
Allergies		
Asthma		
Anemia		
Anxiety		
Bleeding/Blood Clots		
Bronchitis		
Cancer		
Chronic Pain_____		
Chronic Physical Disability		
Depression		
Diabetes		
Heart Disease		
Headaches/Migraines		
Hepatitis/Liver Problems		
High Blood Pressure		
Immune System Problem		
Kidney/Urine Infection		
Pneumonia		
Seizures		
Thyroid Disease		

Family History:

Is there anyone in the family with the following:

	Yes	No	Who
Allergies			
Anemia Mental Illness			
Asthma			
Blood Disorders			
Cholesterol Problem			
Cancer _____			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lung Disease			
Prostate Cancer			
Seizures			
Sickle Cell Trait			
Thyroid Disease			
Tuberculosis			

Have you ever had:

	Yes	No
Problems during intercourse		
Swelling of the testicles		
Weak urine stream		
Difficulty starting urination		
Do you perform testicular self-examination		

	Yes	No
More than one sexual partner in the last year		
Pain during intercourse		
Date of last prostate exam		
Current birth control method		

Hospitalizations:

Surgeries:

Please list all medicines and home treatments you are taking:

	Yes	No	
Are you allergic to any medicines?			What?
Do you smoke?			How much?
Do you abuse alcohol?			How much?
Do you abuse recreational drugs?			Which ones?
Have you ever been to an alcohol/drug treatment program?			Where?
Have you ever tested positive on a tuberculosis skin test?			When?
When was your last tetanus shot?			Year
Have you ever had a pneumonia shot?			Year
Have you ever experienced Domestic Violence, Sexual Abuse or Child Abuse?			What type?

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

Patient Social, Sexual and Psychiatric History

Would you or your partner like to become pregnant in the next year? Yes No

Gender: _____

Sexually Active: Yes No Previously

Orientation: Bisexual Heterosexual Homosexual Other _____

# of current partners:_____ # of lifetime partners:_____

Condom Use: Always Sometimes Never

Birth Control:

Abstinence	Pregnant	Nuva Ring	Menopausal	Oral Contraceptive
Condoms, female	Condoms, male	Contraceptive patch	Spermicide	Rhythm
Depo-Provera	Diaphragm	Vasectomy	Withdrawal	Tubal Ligation
Nexplanon	Total Hysterectomy	Partial Hysterectomy	IUD, Paragard	IUD

Cervical Cap
Contraceptive sponge
Hysteroscopic tubal occlusion
IUD, Mirena

STI:

HIV Status: Negative Positive Not Tested

Date tested_____

Aids: Negative Positive

Are you being treated? _____ Route of HIV transmission _____

History of STIs:

Chlamydia	Gonorrhea	Bacterial Vaginosis	Hepatitis C	HIV/AIDs
Genital Warts	Hepatitis B	Trichomoniasis	Syphilis	Herpes Simplex Virus

Human Papilloma Virus (HPV)

Risk factors for STIs:

None	Prostitution	h/o Blood Transfusion	Perinatal transmission	Promiscuous heterosexual contact
Unprotected sex	Homosexual sex	Sexual contact w/ IVDA	Heterosexual contact	Sex w/hepatitis - infected person
Multiple sex partners	h/o IV drug use	Male who has sex with male(s)	Sexually active before age 18	Hemophilia/coagulation disorder

Abuse/Domestic Violence History:

History of child abuse: Yes No

Offender(s): _____ _____

_____ _____

Type(s): Physical Sexual Verbal

Were you ever placed in a girls'/boys' home, foster home, or group home? Yes No

History of domestic violence: Yes No

Perpetrator(s): _____ _____

_____ _____

Perpetrator in home: Yes No

Restraining order in place: Yes No

Have you ever been convicted of a sexual offense? Yes No

Psychiatric History:

History of suicidal thoughts: Yes No

History of homicidal thoughts: Yes No

Diagnosed with psychiatric condition: Yes No

Diagnosis _____

Psychiatrist name:_____

Phone Number: (_____)_____-_____

Therapist Name: _____

Phone Number: (_____)_____-_____

Consent for communication between psychiatrist & PCP: Yes

Documentation on file? Yes

Consent for communication between therapist & PCP: Yes

Documentation on file? Yes

Family HX of psychiatric condition: Yes

What Psychiatric diagnoses and who_____

Drug Use/Abuse: Age started_____

Use Drugs: Yes No Formerly

Type(s):

Amphetamines	Barbiturates	Cocaine	Crack	
Diazepam	Ecstasy	Heroin	Inhalants	
LSD	Marijuana	Mescaline	Morphine	
Opium	PCP	Peyote	Vicodin	

Frequency: Daily Weekly Monthly Other: _____

Route(s): Injected Inhaled Oral Snorted

Have you quit? Yes No

Sought treatment for drug abuse: Yes No

Date of last treatment _____ # of times _____

Involved in a 12-step program? Currently Formerly No

Emergency medical attention required due to drug use: Yes No

Number of times _____

Family HX of drug abuse: Yes No Who _____

Alcohol Use: Age Started: _____

Sought Treatment for alcohol abuse: Yes No

Date of last treatment _____ # of times _____

Involved in a 12-step program? Currently Formerly No

Have you had withdrawal problems, seizures or blackouts from alcohol or drugs? Yes No

Emergency medical attention required due to intoxication: Yes No

Number of times_____

Family HX of alcoholism: Yes No

Who_____

Incarceration History:

History of incarceration: Yes No

Crime Convicted of:_____

Duration of incarceration: _____ to _____

Facility Type: Juvenile Adult

Duration of probation:_____ to _____

Probation Status: Cleared Court Mandated Treatment

Treatment Status: Cleared Court Mandated Treatment

Duration of treatment:_____ to _____

Tobacco Use:

Current?_____ Former?_____ Never?_____

If Current: Every Day Some days Unknown

Type:_____ Units/day:_____

Ever tried to quit? Yes No Year Quit:_____

Longest Tobacco Free:_____ Relapse Reason:_____

Passive Smoke Exposure? Yes No

Patient Name: _____ DOB: _____ Medical Record #: _____

Mountain Health

TB EXPOSURE RISK ASSESMENT

Evaluation questionnaire to determine if Mantoux tuberculin skin test (TST) is indicated

The health care worker HCW is to ask the following questions during each periodic health assessment.
The following questionnaire was developed was San Diego County TB Control Program

1. Has a family member or any one the patient sees regularly been diagnosed or suspected of being sick with the active TB disease? Yes_____ No_____

2. Does the patient have family members or frequent visitors who were born in high TB prevalence countries (most countries from Asia, Africa, Mexico, Latin America, parts of Eastern Europe)? Yes_____ No_____
3. Was the patient born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Mexico, Latin America, parts of Eastern Europe)? Yes_____ No___

4. Does the patient live in out of home placements (such as foster care or residential facilities)? Yes____ No____

5. Does the patient have HIV infection, or other immunosuppressive conditions? Yes____ No____

6. Does the patient live with an adult with HIV seropositivity? Yes____ No____

7. Does the patient live, or frequently visit, with persons who have been incarcerated in the last 5 years? Yes____ No____

8. Has the patient lived among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes? Yes____ No____

INSTRUCTIONS TO THE HEALTH CARE WORKER:

Administer the Mantoux TB skin test to all children who have any of the above risk factors (indicated be a Yes response) and to children age 4-5 or 13-16 UNLESS:

1. The patient has previously documented** positive Mantoux TST, or
2. The patient has had a TST within the last year.

NOTE:
Trained medical personnel, not parents or guardians, must read the skin test.
**DOCUMENTED = record indicating date of Mantoux and the millimeter result

Health Care Worker completing form:_____ Date:_____

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

DENTAL ASSESSMENT

Mountain Health recommends a dental exam every 6 months

Campo_____ Alpine_____ Escondido_____ 25th_____

Patient's Name_____ **Date**_____
Birth date_____ **Insurance Carrier**_____
Has the patient ever seen the dentist? Yes_____ No_____
If yes: Date of last appointment: _____ Work done_____
Dentist Name_____ **Phone**_____

Does patient drink fluoridated water or take fluoride supplements? Yes_____ No_____
Does patient brush 2x a day with fluoride toothpaste? Yes_____ No_____
Does patient snack on sweets/juices/sodas more than 3x a day? Yes_____ No_____
Are there obvious decay/white spots on teeth? Yes_____ No_____
Is there obvious plaque on teeth? Yes_____ No_____
Does the patient have any developmental delays/special needs? Yes_____ No_____
If Yes_____

For patients 6 and older:
Does the patient have a family history of poor oral health? Yes_____ No_____
Does the patient have missing teeth due to trauma or disease? Yes_____ No_____
Does the patient have any dental/orthodontic appliances? Yes_____ No_____
Does the patient have a history of the following?
Chemo/Radiation Therapy Yes_____ No_____
Severe Dry Mouth Yes_____ No_____
Drug/Alcohol Abuse Yes_____ No_____
Eating Disorders Yes_____ No_____

For patients 0-5 years of age:
Parent/Guardian's Name_____ **Phone**_____
Does the child drink from a bottle? Yes_____ No_____
If yes: What goes into bottle? _____
Does the child go to bed w/ bottle? Yes_____ No_____

First 5 San Diego PARTNER

Patient Name: _____DOB: _____ Medical Record #: _____

Mountain Health

PATIENT HEALTH QUESTIONNAIRE-9
(P H Q - 9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Patient Name: _____DOB: _____ Medical Record #: _____