ANAV TRIBAL HEALTH CLINIC

QUARTZ VALLEY INDIAN RESERVATION

PATIENT REGISTRATION

_____ MEDICAL _____ BEHAVIORAL HEALTH _____ DENTAL

PATIENT'S NAME: _____
LAST FIRST MIDDLE

SEX: ☐MALE ☐FEMALE DOB: _____ SS #: _____ MARITAL STATUS: _____

WHEN DID YOU MOVE TO THIS COMMUNITY: _____ PLACE OF BIRTH: _____
CITY STATE

STREET ADDRESS: _____
CITY STATE ZIP

MAILING ADDRESS: _____
CITY STATE ZIP

TELEPHONE: (_____)_____(_____)_____(_____)_____
HOME WORK CELL /MESSAGE

EMPLOYER/ SCHOOL (IF A STUDENT) _____

INTERNET ACCESS: NO YES IF YES WHERE: HOME/WORK/SCHOOL/HEALTH CARE FACILITY/ LABRARY/ COMMUNITY CENTER

RACE/ETHNICITY ☐AFRICAN AMERICAN ☐ASIAN ☐FILIPINO ☐HISPANIC ☐NATIVE AMERICAN/ALASKAN NATIVE

[ ]OTHER _____ ☐PACIFIC ISLANDER ☐WHITE RELIGIOUS PREFERENCE: _____

FINANCIAL RESPONSIBILITY ARE YOU A US VETERAN ☐NO ☐YES DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

DENTAL INSURANCE:☐NO ☐YES MEDICAL INSURANCE:☐NO☐YES MEDI-CAL:☐NO☐YES MEDICARE:☐NO☐YES

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____

SS # _____ DOB: _____ EMPLOYER: _____

INCOME INFORMATION: FAMILY SIZE: _____ MONTHLY INCOME: _____ ANNUAL INCOME: _____

FATHER'S FULL NAME: _____ DOB: _____ PLACE OF BIRTH: _____
CITY STATE

EMPLOYER: (If a minor) _____

MOTHER'S FULL MADIEN NAME: _____ DOB: _____ PLACE OF BIRTH: _____
CITY STATE

EMPLOYER: (If a minor) _____

EMERGENCY CONTACT (If a minor please list parent or guardian as the emergency contact)

NAME: _____ TELEPHONE #: _____

REALTIONSHIP: _____ STREET ADDRESS: _____
CITY STATE ZIP

NEXT OF KIN

NAME: _____ TELEPHONE #: _____

REALTIONSHIP: _____ STREET ADDRESS: _____
CITY STATE ZIP

Release of Information/ Assignment of Benefits: ATHC has my permission to release information as needed for insurance processing and for my insurance to release payment to Anav Tribal Health Clinic. **I HEARBY AUTHORIZE TREATMENT**

Patient, Parent or Guardian: _____ Printed Name: _____ Date: _____

Present: ☐Proof of Identification ☐ Native Verification ☐ Insurance Card(s) INITIALS OF SCREENER: _____

HRN: _____

Anav Tribal Health Clinic Standard Adult Health Questionnaire

Name:_____. Age: _____. Date: _____.

Address: _____. Phone No.:(___) _____.

History Of Past Illness: Have you had....(circle any that apply)
Measles Mumps Chicken Pox Diabetes Strokes Cancer Heart Disease Rheumatic Fever Artitis
Tuberculosis Sexually Transmitted Disease Congenital Abnormalities

Other serious disease No Yes What disease?
Have you had any other serious illness? ☐ No ☐ Yes
Have you ever been hospitalized or been under medical care for very long? ☐ No ☐ Yes
If yes, for what reason?

Operations: Have you had any surgery? _____

List (with dates if you know them): _____

_____

Injuries: Have you had any broken bones? ☐ No ☐ Yes
Have you had any other serious injuries? ☐ No ☐ Yes
Have you ever been knocked unconscious? ☐ No ☐ Yes

If Yes, explain: _____.

_____

FAMILY HISTORY	IF LIVING:	IF DECEASED	HAS ANY BLOOD RELATIVE
Father:			Cancer No ☐ Yes ☐
Mother:			Tuberculosis No ☐ Yes ☐
Brothers:			Diabetes No ☐ Yes ☐
			Heart Trouble No ☐ Yes ☐
			High Blood Pressure No ☐ Yes ☐
Sisters:			Stroke No ☐ Yes ☐
			Epilepsy No ☐ Yes ☐
Spouse:			Suicide No ☐ Yes ☐
Sons:			Mental Illness No ☐ Yes ☐
			Bleeding Tendency No ☐ Yes ☐
			Gout No ☐ Yes ☐
Daughters:			Severe Arthritis No ☐ Yes ☐

Anav Tribal Health Clinic Standard Adult Health Questionnaire

Social History: (circle one) Single Married Separated Divorced Widowed

Are you living with your spouse or significant other? No ☐ Yes ☐

Do you have concerns about your sex life? No ☐ Yes ☐

Do you have dependents at home? No ☐ Yes ☐

Do You Use Alcoholic Beverages? Yes, What kind? _____ How much?_____.
If No, did you ever?_____ When quit?_____.

Do You Use Tobacco? Yes, Cigarettes?____ packs a day for____years.
Chewing Tabacco?_____ If no, did you ever?_____.
When did you quit: Cigarettes?_____ Chew?_____.

Are you employed? Full-Time Part-Time Are you on disability? For what condition?

_____

What is your job? (If retired/disabled, what job(s) did you so previously?) _____

_____

What do you do for exercise? _____ How often?_____

Have you been exposed to fumes, dusts, asbestos or solvents? _____

Education: (years)
Grade School _____
High School _____
College _____
Post Graduate _____

How much time have you lost from work because of your health during the past:
Six Months? _____
One Year? _____
Five Years? _____

Do you have any of the following?

GENERAL:			HEAD-EYES-EARS-NOSE-THROAT cont.:		
Recent weight change?	N ☐	Y ☐	Impaired hearing	N ☐	Y ☐
Do you eat fruits and vegetables daily?	N ☐	Y ☐	Constant ringing in the ears	N ☐	Y ☐
Have you been n good general health?	N ☐	Y ☐	Frequent sore throats	N ☐	Y ☐
SKIN:			Frequent mouth sores	N ☐	Y ☐
Jaundice (skin/eyes turned yellow)	N ☐	Y ☐	Dentures	N ☐	Y ☐
Hives, eczema or chronic rash	N ☐	Y ☐	Tooth pain or problems	N ☐	Y ☐
Frequent infections or boils	N ☐	Y ☐	NECK:		
Any skin lesion that is growing, bleeding or changing	N ☐	Y ☐	Stiffness	N ☐	Y ☐
Other skin disease	N ☐	Y ☐	Thyroid trouble	N ☐	Y ☐
HEAD-EYES-EARS-NOSE-THROAT:			Enlarged glans	N ☐	Y ☐
Eye disease	N ☐	Y ☐	RESPIRATORY:		
Do you wear glasses/contact lenses	N ☐	Y ☐	Do you have a "cold" now	N ☐	Y ☐
Double vision	N ☐	Y ☐	Coughing up blood	N ☐	Y ☐
Headaches	N ☐	Y ☐	Chronic or frequent cough	N ☐	Y ☐
Glaucoma	N ☐	Y ☐	Asthma or wheezing	N ☐	Y ☐
Itching eyes or nose or ears	N ☐	Y ☐	Difficulty breathing	N ☐	Y ☐
Sneezing or runny nose	N ☐	Y ☐	Any trouble with lungs	N ☐	Y ☐
Nosebleeds	N ☐	Y ☐			

Anav Tribal Health Clinic Standard Adult Health Questionnaire

Patient Name: _____ Date: _____

CARDIOVASCULAR:			GYNECOLOGICAL:		
Chest pain or angina pectoris	N ☐	Y ☐	Date of first day of last period:		
Shortness of breath with walking or laying down	N ☐	Y ☐	Age periods began:		
Difficulty walking two blocks	N ☐	Y ☐	How many days do periods last:		
Heart trouble or heart attacks	N ☐	Y ☐	Frequency of periods, every days		
High blood pressure	N ☐	Y ☐	Any pain with your periods	N ☐	Y ☐
Swelling of hands, feet or ankles	N ☐	Y ☐	How many times have you been pregnant?		
Awakening in the night smothering	N ☐	Y ☐	Number of children Ages:		
Heart Murmur	N ☐	Y ☐	Do you practice breast self-examination?	N ☐	Y ☐
GASTROINTESTINAL:			When was your last mammogram		
Constipation	N ☐	Y ☐	Date of last cancer smear and results		
Ulcer	N ☐	Y ☐	Vaginal discharge, itch or burning	N ☐	Y ☐
Vomiting blood or food	N ☐	Y ☐	MALE:		
Gallbladder disease	N ☐	Y ☐	Prostate problems	N ☐	Y ☐
Liver trouble	N ☐	Y ☐	Discharge from the penis or sore on penis	N ☐	Y ☐
Hepatitis	N ☐	Y ☐	Testicle problens	N ☐	Y ☐
Painful bowel movements	N ☐	Y ☐	MUSCULOSKELETAL:		
Bleeding with bowel movement	N ☐	Y ☐	Varicose veins	N ☐	Y ☐
Black bowel movements	N ☐	Y ☐	Weakness of muscles or joints	N ☐	Y ☐
Hemorrhoids or piles	N ☐	Y ☐	Any difficulty walking	N ☐	Y ☐
Recent change in bowel habits	N ☐	Y ☐	Pain in calves or buttocks on walking		
Diverticulitis	N ☐	Y ☐	Relieved by rest?	N ☐	Y ☐
Pancreatitis	N ☐	Y ☐	HEMATOLOGIC:		
Frequent diarrhea	N ☐	Y ☐	Frequent nose bleeds	N ☐	Y ☐
Heartburn or indigestion	N ☐	Y ☐	Blood disease	N ☐	Y ☐
Cramping or pain in the abdomen	N ☐	Y ☐	Anemia	N ☐	Y ☐
Does food stick in your throat?	N ☐	Y ☐	Blood clot in leg or lung	N ☐	Y ☐
Hernia	N ☐	Y ☐	Heavy bleeding after dental work or surgery	N ☐	Y ☐
GENITOURINARY:			Have you had a blood transfusion	N ☐	Y ☐
Do you leak urine during the day or night?	N ☐	Y ☐	Abnormal bleeding or bruising	N ☐	Y ☐
Frequent urination	N ☐	Y ☐	ENDOCRINE:		
Night time urinating? If so, how many times?	N ☐	Y ☐	Thyroid disease	N ☐	Y ☐
Painful or burning urination	N ☐	Y ☐	Hormone therapy	N ☐	Y ☐
Blood in urine	N ☐	Y ☐	Diabetes	N ☐	Y ☐
Kidney trouble	N ☐	Y ☐	Change in hair growth	N ☐	Y ☐
Kidney stones	N ☐	Y ☐	Change in hat or glove size	N ☐	Y ☐
NEURO-PSYCHIATRIC:			IMMUNIZATIONS:		
Have you had a stroke?	N ☐	Y ☐	When was your last tetanus shot?		
Have you ever had psychiatric care?	N ☐	Y ☐	Have you ever had pneumonia vaccine?	N ☐	Y ☐
Have you been advised to see a psychiatrist?	N ☐	Y ☐	If so, when?		
Do you ever have fainting spells?	N ☐	Y ☐	Do you get flu shots?	N ☐	Y ☐
Convulsions or epilepsy?	N ☐	Y ☐	SAFETY:		
Frequent numbness of arm, leg, other body part?	N ☐	Y ☐	Do you feel safe in your home?	N ☐	Y ☐
Do you fall frequently?	N ☐	Y ☐	Has any one threatened you in the past year?	N ☐	Y ☐
Have you felt sad or hopeless for days at a time?	N ☐	Y ☐	Has anyone hit you in the past year?	N ☐	Y ☐
Do you feel depressed or overwhelmed?	N ☐	Y ☐	Do you have enough food to eat?	N ☐	Y ☐
Lost interest in things that used to be fun?	N ☐	Y ☐			
Do you just what to be alone?	N ☐	Y ☐			

Anav Tribal Health Clinic Standard Adult Health Questionnaire

Allergies

Are you allergic to any medication, or have you had a bad reaciton to any medication? If so, which medications and what was the reaction you had? _____

_____

_____

Do you have any other allergies or senitivities? If so, please list..... _____

_____

_____

Medications

Are you currently taking any prescription medication, or over-the-counter medication, vitamins, herbal medications, or supplements? If so, please list..... _____

_____

_____

_____

_____

Signature of Patient _____ Date: _____

Clinician: _____ Date: _____

If other than patient, Signature of Person filling out this form: _____

Anav Tribal Health Clinic
Medical/Dental Department
Broken Appointment Policy/ Form

You are important to us, and we want to provide you with the best possible service. Our staff is working hard to provide quality medical/dental care to all our patients. Our appointment schedule is always filled far in advance. Broken appointments waste valuable time for other patients who are trying to get in for treatment.

To be able to best utilize the available time, we have the following policy.

Broken Appointment Policy:
Any patient who breaks two (2) appointments within a six-month period will be seen on an emergency basis only, as determined by the triage nurse/dental receptionist, for six months.

You will receive a broken appointment if:

1. You do not cancel your appointment with at least 24 hours' notice.
2. You do not appear for an appointment.
3. You are more than 10 minutes late for your appointment.

Confirming Appointment:
I hereby give my consent for the medical/dental staff to call and confirm my medical/dental appointment, by contacting me at my daytime phone number. If I do not wish to be contacted at this number, I will provide an alternate means of contacting me.

Day time phone #_____ Alternate #_____

I understand it is my responsibility to notify this office before my appointment time if I am unable to keep my appointment.

I have read and understand the broken appointment policy and confirmation consent.

_____ _____
Patient/Parent/Guardian Signature Date

Office Use only:

Provider	Broken Appointment Date	Staff Initials
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Acknowledgement of Receipt of IHS/ATHC Notice of Privacy Practices

I hereby acknowledge receipt of Anav Tribal Health Clinic IHS/ATHC Notice of Privacy Practices At:

ANAV TRIBAL HEALTH CLINIC
9024 SNIKTAW LANE
FORT JONES, CA 96032

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(State relationship to Patient) OR
Signature of Witness (if signature is a thumbprint of mark)

_____ _____
Signature and Title of ATHC Employee Date

For Patients Unable To Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS/ATHC Notice of Practices because:

_____

_____

_____

_____ _____
Signature of ATHC Staff Date

Patient Responsibility

It is the patient's responsibility to wait in the clinic waiting area until called. While waiting, it's the patient's responsibility to be courteous, kind, considerate to other patients waiting to be seen.

It is the patient's responsibility to control their children and keep them quiet, and while parent or surrogate is being treated to seek care for the children prior to his/her visit. It is a parent's responsibility to understand that staff is unable to watch children during clinic hours.

It is the patient's responsibility to conduct themselves in an orderly manner, and to understand that voiced or physical hostility will not be tolerated under any circumstances.

It is the patient's responsibility to be respectful and considerate to all staff members.

It is the patient's responsibility to understand that disruptive behavior will be cause for refusal of services. Services may be continued at a later time, if proper behavior has been established.

I have read and understand the Patient's Responsibility and confirm Responsibility.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature Date

_____ _____

Witness Signature Date

ANAV TRIBAL HEALTH CLINIC

Consent For Treatment:

I, (print name)_____ the undersigned, do hereby consent to routine medical/dental care and treatment for (patient name)
from the individuals who make up the health care team of the Anav Tribal Health Clinic.

Release of Information:

It is understood that the information in my health record will be made available in the clinic; pertinent information from my health record may be shared with the other health care provider(s) to whom I am referred.

"Special patient permission" is needed to release this information if the patient is treated for alcohol or drug abuse.

Assignment of Benefits:

For the purpose of insurance/payment reimbursement, the undersigned agrees that to the extent necessary to determine liability for payment and to obtain the reimbursement, the Anav Tribal Health Clinic may disclose portions of the patient's record. In addition disclosure of his/her record may be made to any individual of corporation, which is or who may be liable for all or any portion of the Anav Tribal Health Clinic's charges. This includes, but is not limited to insurance companies, health care service plans, or worker's compensation carriers.

The undersigned also assigns any health care benefits the Anav Tribal Health Clinic and authorizes health care benefits to be paid directly to the Anav Tribal Health Clinic.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian's Signature Date

_____ _____
Witness' Signature Date