****

**Registration Form - Pediatric**

Choose an item.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Today’s Date:** | | | | | | | | | | **PCP:** | | | | | | | | | | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s Legal Last Name: First: Middle:** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Previous Names Used/Alias:** | | | | | **Birth Date:**  / / | | | | | **Age:** | | | | | | | **Social Security #:** | | | | | | | **Sex at Birth:** MFOther | | | |
| **Mailing Address:** | | | | | | | | | | | | | **City:** | | | | | | | | **State:** | | | | **Zip:** | | |
| **Parent 1 Name:** | | | | | | | | **Cell Phone:** | | | | | | | | | | | | | | **Work Phone:** | | | | | |
| **Parent 2 Name:** | | | | | | | | **Cell Phone:** | | | | | | | | | | | | | | **Work Phone:** | | | | | |
| **Parent 1 E-Mail Address:** | | | | | | | | | | | | | | **Parent 2 E-Mail Address:** | | | | | | | | | | | | | |
| **Best way to contact for results, follow up, or scheduling? (check all that apply)**  ❑ Parent 1 Cell ❑ Parent 1 Work ❑ Parent 2 Cell ❑Parent 2 Work ❑ Parent 1 Email ❑ Parent 2 Email | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child’s Race:**  Alaska Native  Pacific Islander | | Native Hawaiian  Asian  White | | | | American Indian  Black or African American | | | | | | | | | Unknown  Choose not to disclose | | | | | | | | **Child’s Ethnicity:**  Hispanic Not Hispanic  Unknown Choose not to disclose | | | | |
| **Child’s Sexual Orientation:**  Lesbian or gay   Straight (not lesbian or gay)   Bisexual  Something else\_\_\_\_\_\_\_\_\_\_\_   Don’t know  Choose not to disclose | | | **Child’s Gender Identity:** Female Male   Transgender Female / Male-to-Female   Transgender Male / Female-to-Male Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Choose not to disclose | | | | | | | | | | | | | | | | | **Preferred Pronoun:**   she/her/hers   he/him/his   they/them/theirs   patient’s name   decline to answer   unknown | | | | | | | |
| **Family’s Homeless Status:** | Not Homeless  At Risk for Homeless Transitional Housing | | | | | | Living with Others  Homeless, Unknown Shelter Living in Shelter | | | | | | | | | | | | Street, Camp, Bridge Currently Not Homeless, Was in the Last 12 Months | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | **Relationship to patient:** | | | | | | | | | | | | **Phone Number:** | | | | | | | | | | **Ok to leave voicemail:** | |
|  | | | |  | | | | | | | | | | | | Home Mobile Work | | | | | | | | | | YesNo | |
| **PARENT EMPLOYMENT STATUS** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Farm Work Recognition:** Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming? Yes No   Migrant – You or a member of your household has established a temporary home to do farm work  Seasonal – You or a member of your household do farm work that only happens at certain times of year | | | | | | | | | | | | | | | | | | | | | | | | | | | **Is either parent a Veteran?** Yes No |
| **Number of Family Members:** | | | | | | | | | | | **Monthly Income (before taxes) $** | | | | | | | | | | | | | | | | |
| **LANGUAGE** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **What language do you speak at your home:**  English Spanish Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | **Interpreter Needed:** Yes No  **Preferred:** Male Female No Preference | | | | | | | | | | | |
| **RESPONSIBLE PARTY**  If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent/Legal Guardian Responsible for Bill:** | | | | | | | | | **Birth Date:**  **/ /** | | | | | | | | | **Social Security # of Parent/Legal Guardian:** | | | | | | | | | |
| **Mailing Address:**  Same as above | | | | | | | | | | | | **City:** | | | | | | | | | **State:** | | | | **Zip:** | | |
| **Phone Number:** | | | | | | | | | | | | Home Mobile Work | | | | | | | | | | | | | | | |

|  |
| --- |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neighborhood Health Center or insurance company to release any information required to process my claims.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***Date***  ***Patient/Guardian signature*** |
| FOR OFFICE USE ONLY |
| Initials for Special Confidentiality: Screen By: Total Income: $ |
| TITLE X: Clients pay % per sliding fee scale for non-FPEP covered service. |
| Address Verification: □ Yes Date/Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Patient declined confidentiality |

**Pediatric Confidential Health & Social History (0-2 yrs)**

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your baby and support for you.

Baby’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person filling out form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
I am this baby’s: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby taking any medication regularly? ❑ No ❑ Yes If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Has your baby been vaccinated? ❑ No ❑ Yes Are your baby’s vaccinations up-to-date? ❑ No ❑ Yes ❑ Not sure

**BABY’S HEALTH PROBLEMS (Check box if your baby has had any of these)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ❑ Anemia | ❑ Eye / Vision Problem | | ❑ Mononucleosis | | ❑ Stomachaches | |
| ❑ Asthma / Breathing Problem | ❑ Headaches | | ❑ Pneumonia | | ❑ Toothache / Decay | |
| ❑ Bone / Joint / Muscle Problem | ❑ Heart Disease / Murmur | | ❑ Rheumatic Fever | | ❑ Tuberculosis | |
| ❑ Chicken pox | ❑ Hepatitis | | ❑ Seizures / Epilepsy | | ❑ Usual Bruising / Bleeding Disorder | |
| ❑ Diabetes | ❑ Kidney / Bladder Problem | | ❑ Sickle Cell | | ❑ Whooping Cough | |
| ❑ Ear / Hearing Problem | ❑Other: |  | | | | |
|  | | | | | | |
| Has your baby been hospitalized or had surgery? ❑ No ❑ Yes When / why: | | | |  | | |
| Does your baby have any allergies (medicine, foods, or seasonal)? ❑ No ❑ Yes If yes, what: | | | | | |  |
|  | | | | | | |
| Has your baby ever been beaten, shaken, or otherwise physically hurt by someone? ❑ No ❑ Yes | | | | | | |
| Has anybody touched your baby on their private areas without your or your baby’s permission? ❑ No ❑ Yes | | | | | | |

**MOTHER’S PREGNANCY & BABY’S BIRTH HISTORY (If you filled out this form at NHC in the past, you may skip this section)**

Number of pregnancies: \_\_\_\_\_\_ Miscarriages: \_\_\_\_\_\_\_\_ Abortions: \_\_\_\_\_\_\_ Number of living children: \_\_\_\_\_\_\_\_\_\_\_

Did mother receive prenatal care? ❑ No ❑ Yes How many months pregnant when prenatal care began? \_\_\_\_\_\_\_\_\_

Did mother have any problems during pregnancy / labor / delivery? ❑ No ❑ Yes If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did mother use any drugs or medicines during pregnancy? ❑ No ❑ Yes

|  |  |  |
| --- | --- | --- |
| ❑ Alcohol | ❑ Street drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Over the counter medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Tobacco | ❑ Needles to shoot up drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Other medicines prescribed by doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has mother had treatment for drug/alcohol use? ❑ No ❑ Yes If yes, is mother currently using drugs/alcohol ❑ No ❑ Yes

Birth weight: \_\_\_\_\_\_\_\_\_\_pounds\_\_\_\_\_\_\_\_ ounces Birth length: \_\_\_\_\_\_\_\_\_\_inches

Born at: ❑ Hospital-Name of hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_❑ Home Delivery: ❑ Vaginal ❑ Cesarean

Place of Birth: City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was baby born prematurely? ❑ No ❑ Yes # of weeks pregnant at delivery? \_\_\_\_\_\_\_\_\_

**BABY’S DEVELOPMENT**

Do you believe, or has anyone told you, that your baby is developmentally delayed?❑ No ❑ Yes

**BABY’S DENTAL HISTORY**

Has your baby ever been to the dentist? ❑ No ❑ Yes

Do you brush your baby’s teeth and mouth daily? ❑ No ❑ Yes

Does your baby use a toothpaste with fluoride in it? ❑ No ❑ Yes

Does your baby take a fluoride supplement? ❑ No ❑ Yes

Do you have any concerns about your baby’s teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY (Check if a family member had any of these. Family = Your baby’s brother, sister, mother, father, grandmother, grandfather)**

|  |  |  |
| --- | --- | --- |
| ❑ Alcohol / Drug Problem | ❑ Heart Attack before age 50 | ❑ Mental Retardation |
| ❑ Birth Defects | ❑ Hepatitis | ❑Sickle Cell Anemia |
| ❑ Cancer | ❑ High Cholesterol | ❑ SIDS (Sudden Infant Death) |
| ❑ Diabetes | ❑ High Blood Pressure | ❑ Smoking |
| ❑ Epilepsy / Seizures | ❑ Kidney Disease | ❑ Stroke before age 50 |
| ❑ Hearing Loss | ❑ Mental Illness | ❑ Tuberculosis |

**FAMILY HEALTH HABITS & ACTIVITIES**

Baby’s parents are: ❑ Married, living together ❑ Married, living apart ❑ Not married, living together

❑Not married, living apart ❑ Divorced ❑ Separated ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Baby lives: ❑ In a house or apartment ❑ In a car or van ❑ In a shelter ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest grade or year of school you completed? 🞎 No school or only kindergarten ❑ Grade 1 -8 ❑ Some high school ❑ Finished high school ❑ Some college ❑ Finished college or graduate school

Does your baby have any special problems, concerns, or other information you feel your provider should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY NEEDS**

How hard is it to pay for basics, like food, housing, heating and medical care?

|  |  |  |
| --- | --- | --- |
| ❑ Very hard | ❑ Somewhat hard | ❑ Not hard |
|  |  |  |
| If you marked “very hard” or “somewhat hard” which ones do you find hard to pay for? | | |
| ❑ Food | ❑ Transportation | ❑ Child care |
| ❑ Housing or utilities | ❑ Clothing | ❑Medical or dental care |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pediatric Confidential Health & Social History (3-10 yrs)**

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your child and support for you.

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person filling out form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
I am this child’s: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any medication regularly? ❑ No ❑ Yes If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Has your child been vaccinated? ❑ No ❑ Yes Are your child’s vaccinations up-to-date? ❑ No ❑ Yes ❑ Not sure

**CHILD’S HEALTH PROBLEMS (Check box if your child has had any of these)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ❑ Anemia | ❑ Eye / Vision Problem | | ❑ Mononucleosis | | ❑ Stomachaches | |
| ❑ Asthma / Breathing Problem | ❑ Headaches | | ❑ Pneumonia | | ❑ Toothache / Decay | |
| ❑ Bone / Joint / Muscle Problem | ❑ Heart Disease / Murmur | | ❑ Rheumatic Fever | | ❑ Tuberculosis | |
| ❑ Chicken pox | ❑ Hepatitis | | ❑ Seizures / Epilepsy | | ❑ Usual Bruising / Bleeding Disorder | |
| ❑ Diabetes | ❑ Kidney / Bladder Problem | | ❑ Sickle Cell | | ❑ Whooping Cough | |
| ❑ Ear / Hearing Problem | ❑Other: |  | | | | |
|  | | | | | | |
| Has your child been hospitalized or had surgery? ❑ No ❑ Yes When / why: | | | |  | | |
| Does your child have any allergies (medicine, foods, or seasonal)? ❑ No ❑ Yes If yes, what: | | | | | |  |
|  | | | | | | |
| Has your child ever been beaten, shaken, or otherwise physically hurt by someone? ❑ No ❑ Yes | | | | | | |
| Has anybody touched your child on their private areas without your or your child’s permission? ❑ No ❑ Yes | | | | | | |

**CHILD’S DEVELOPMENT**

Do you believe, or has anyone told you, that your child is developmentally delayed?❑ No ❑ Yes

**CHILD’S DENTAL HISTORY**

Has your child ever been to the dentist? ❑ No ❑ Yes

Has your child ever had a problem at a dentist appointment? ❑ No ❑ Yes

Does your child brush his/her teeth and mouth daily? ❑ No ❑ Yes

Does your child floss daily? ❑ No ❑ Yes

Does your child use a toothpaste with fluoride in it? ❑ No ❑ Yes

Does your child take a fluoride supplement? ❑ No ❑ Yes

Do you have any concerns about your child’s teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY (Check if a family member had any of these. Family = Your child’s brother, sister, mother, father, grandmother, grandfather)**

|  |  |  |
| --- | --- | --- |
| ❑ Alcohol / Drug Problem | ❑ Heart Attack before age 50 | ❑ Mental Retardation |
| ❑ Birth Defects | ❑ Hepatitis | ❑Sickle Cell Anemia |
| ❑ Cancer | ❑ High Cholesterol | ❑ SIDS (Sudden Infant Death) |
| ❑ Diabetes | ❑ High Blood Pressure | ❑ Smoking |
| ❑ Epilepsy / Seizures | ❑ Kidney Disease | ❑ Stroke before age 50 |
| ❑ Hearing Loss | ❑ Mental Illness | ❑ Tuberculosis |

Did mother use any drugs or medicines during pregnancy? ❑ No ❑ Yes

|  |  |  |
| --- | --- | --- |
| ❑ Alcohol | ❑ Street drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Over the counter medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Tobacco | ❑ Needles to shoot up drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Other medicines prescribed by doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has mother had treatment for drug/alcohol use? ❑ No ❑ Yes If yes, is mother currently using drugs/alcohol ❑ No ❑ Yes

**FAMILY HEALTH HABITS & ACTIVITIES**

Child’s parents are: ❑ Married, living together ❑ Married, living apart ❑ Not married, living together

❑Not married, living apart ❑ Divorced ❑ Separated ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child lives: ❑ In a house or apartment ❑ In a car or van ❑ In a shelter ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the highest grade or year of school you completed? 🞎 No school or only kindergarten ❑ Grade 1 -8 ❑ Some high school ❑ Finished high school ❑ Some college ❑ Finished college or graduate school

Does your child have any special problems, concerns, or other information you feel your provider should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY NEEDS**

How hard is it to pay for basics, like food, housing, heating and medical care?

|  |  |  |
| --- | --- | --- |
| ❑ Very hard | ❑ Somewhat hard | ❑ Not hard |
|  |  |  |
| If you marked “very hard” or “somewhat hard” which ones do you find hard to pay for? | | |
| ❑ Food | ❑ Transportation | ❑ Child care |
| ❑ Housing or utilities | ❑ Clothing | ❑Medical or dental care |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ROI EXAMPLE

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 1** | | | | | |  | | | | | | | |  | |  | | |  | | | | |  | |  |
| Patient Name: | |  | | | | | | | | | | | | | | | | | Date of Birth: | | | | | / / | |  |
| Previous Name: | | |  | | | | | | | | | | |  | |  | | | Social Security #: | | | | |  | |  |
|  | | | | | |  | | | | | | | |  | |  | | |  | | | | |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 2** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Purpose of this disclosure (check all that apply):** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ Transfer or coordination of Patient Care | | | | | | | | | | | | □ At Request of the Patient | | | | | | | | | □ Legal | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I request and authorize the individual/Clinic/Provider listed below to release/receive a copy of my medical, dental, and behavioral health record:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| □ Send my records **from NHC to**: | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| □ Send my records **to NHC from**: | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| NHC and Women Infant and Children (WIC) may share information about your child’s health verbally and in written  form. If you **do** **NOT** want your child’s health information shared between NHC and WIC, please initial here. \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 4** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | |  | |  | | | | | | | |  | | |
|  | Name of Individual/Clinic/Provider | | | | | | | | | | | | |  | | Phone | | | | |  | | |  | | |
|  |  | | | | | | | | | | | | |  | |  | | | | | | | |  | | |
|  | Address | | | | | | | | | | | | |  | | Fax | | | | |  | | |  | | |
|  |  | | | | |  | |  | |  | | |  | |  | |  | | | | |  | | |  | |
|  | City | | | | |  | | State | |  | | | Zip Code | |  | |  | | | | |  | | |  | |
|  | | | | | |  | | | | | | | |  | |  | | | | |  | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Section 5** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **This authorization gives permission to release the following records:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ● Problem list | | | | | | | ● Immunization record | | | | | | | | | | | | | ● Medication List | | | | | | |
| ● Last three progress notes | | | | | | | ● All labs and diagnostic studies from previous year | | | | | | | | | | | | | ● Dental records and radiographs | | | | | |  |
| ● Other (describe): | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
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| **Section 6** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I understand that certain information cannot be released without specific permission as required by State/Federal law. By INITIALING, I authorize the release of the following protected or sensitive information.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please Initial** | | | |  | | | | | | | | | |  | | | | **Please Initial** | | | | |  |  | | |
|  |  | | | Drug/Alcohol Diagnosis/Treatment/Referral Information | | | | | | | | | | | | | |  | | | | | STD/AIDS/HIV Testing | | | |
|  |  | | | Mental Health Diagnosis/Treatment | | | | | | | | | | | | | |  | | | | | Genetic Testing | | | |
|  |  | | |  | | | | | | | | | |  | | | |  | | | | |  |  | | |

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**Signature** (Patient, Guardian, or Authorized Person)  **Relationship to Patient Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name of Person Signing Form**

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Neighborhood Health Center and state that you are revoking this authorization. Unless revoked earlier, this consent will expire upon the event or date indicated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or after one year from the date signed if left blank.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.516) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.