

## Patient Registration Form

<i>Office use only</i>								
MR#:	PCP:	Date of Visit:						
<b>Patient Information</b>								
Last Name:			First:			Middle:		
Maiden Name:			Any other names or aliases:					
Date of Birth:	Social Security Number:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
PHONE NUMBERS Please indicate the number where you prefer to receive calls from the clinic & whether we may leave a message for you.				Home Phone: (      ) <input type="checkbox"/> Preferred		Work Phone: (      ) <input type="checkbox"/> Preferred		
				Cell Phone: (      ) <input type="checkbox"/> Preferred				
Mailing Address:			City:		State:	Zip Code:		
Home Address (if different from Mailing):			City:		State:	Zip Code:		
E-mail:				<b>Primary Language if not English:</b>				
<b>Race (optional):</b>	<input type="checkbox"/> White/Caucasian		<input type="checkbox"/> Black/African American		<input type="checkbox"/> Asian		<input type="checkbox"/> Native Hawaiian	
	<input type="checkbox"/> Other Pacific Islander		<input type="checkbox"/> Native American/Alaska Native		<input type="checkbox"/> More than one Race			
<b>Ethnicity/ethnic origin: (optional)</b>	<input type="checkbox"/> Brazilian		<input type="checkbox"/> Cape Verdean		<input type="checkbox"/> European		<input type="checkbox"/> Jamaican	
	<input type="checkbox"/> Other (please specify): _____							
<b>Insurance Information</b>								
INSURANCE ID# _____				<input type="checkbox"/> No Insurance				
Insurance (check all that apply):								
<input type="checkbox"/> Applied (pending)			<input type="checkbox"/> Medicare			<input type="checkbox"/> Tricare		
<input type="checkbox"/> Mass Health			<input type="checkbox"/> Harvard Pilgrim			<input type="checkbox"/> Veterans		
<input type="checkbox"/> Commonwealth Care			<input type="checkbox"/> Blue Cross/Blue Shield			<input type="checkbox"/> Other (please specify): _____		
<input type="checkbox"/> Health Safety Net (formerly Free Care)			<input type="checkbox"/> Tufts					
EMPLOYMENT STATUS: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal <input type="checkbox"/> None						Are you a US VETERAN? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OCCUPATION:				EMPLOYER:				
Major Income Source: <input type="checkbox"/> Employment <input type="checkbox"/> Social Security <input type="checkbox"/> Disability <input type="checkbox"/> Unemployment <input type="checkbox"/> VA Benefits <input type="checkbox"/> SSI <input type="checkbox"/> Pension								
<b>Annual Household Income</b>								
<i>For grant reporting purposes only. No personally identifiable information is ever reported. This section helps us to receive funding to provide services to the community. Please circle one box based on # of people in your household and total annual income.</i>								
Household:	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>
Annual Income:	\$10,400 or less	\$14,000 or less	\$17,600 or less	\$21,200 or less	\$24,800 or less	\$28,400 or less	\$32,000 or less	\$35,600 or less
<input type="checkbox"/> Prefer not to answer	\$10,401-15,600	\$14,001 – 21,000	\$17,601-25,400	\$21,201-31,800	\$24,801-37,200	\$28,401-42,600	\$32,001-48,000	\$35,601-53,400
	\$15,601-20,800	\$21,001-28,000	\$25,401-35,200	\$31,801-42,400	\$37,201-49,600	\$42,601-56,800	\$48,001-64,000	\$53,401-71,200
	\$20,801-31,200	\$28,001-42,000	\$35,201-52,800	\$42,401-63,600	\$49,601-74,400	\$56,801-85,200	\$64,001-96,000	\$71,201-106,800
	\$31,200-41,600	\$42,001-56,000	\$52,801-70,400	\$63,601-84,800	\$74,401-99,200	\$85,201-113,600	\$96,001-128,000	\$106,801-142,400
	Over \$41,600	Over \$56,000	Over \$70,400	Over \$84,800	Over \$99,200	Over \$113,600	Over \$128,000	Over \$142,400
Referred by: <input type="checkbox"/> Friend <input type="checkbox"/> Employer <input type="checkbox"/> Newspaper <input type="checkbox"/> Social Service Agency <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor <input type="checkbox"/> Other								
Name of Emergency Contact:				Relationship to patient:				
Phone Number:								
<b>Patient or Guardian Signature:</b>						Date:		
Screener Signature:						Date:		



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

Name of person completing form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

## Pediatric Health History Questionnaire

Please complete the below information. Answers to the questions remain confidential and will become part of the child's medical record. The only time we are unable to keep information confidential is when there is a risk of harm to your child or another family member. In those situations we will make a safety plan and discuss how to proceed.

Child's name (last, first, M.I.): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Please circle: Female Male

What are the main strengths about the child?

\_\_\_\_\_

What are your main concerns about the child?

\_\_\_\_\_

<b>CHILD HEALTH HISTORY</b>
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**PREGNANCY and BIRTH HISTORY:**

Were there any maternal illnesses during pregnancy? Please explain:	Yes	No
Were any medications taken during pregnancy? Please list:	Yes	No
Was there any substance use during pregnancy? Please explain:	Yes	No
Where was the patient born (town/city and state):		
How long was the pregnancy:		
Please circle the type of delivery:      Vaginal                  Cesarean		
Were there any problems during labor or delivery? Please explain	Yes	No
What was the baby's birth weight?		
Were there any problems after birth? Please explain:	Yes	No
<b>Is the child up to date on all immunizations?</b> If no, please explain:	Yes	No
Please bring a copy of immunization record to your health care provider.		
<b>Is the child currently receiving dental care?</b> If yes, please provide their name, address, and phone/fax numbers:	Yes	No

List any medical problems other doctors have diagnosed \_\_\_\_\_

\_\_\_\_\_

**Please check any of the following that the child has a history of:**

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent ear infections                                     | <input type="checkbox"/> Asthma                             |
| <input type="checkbox"/> Jaundice (yellow skin)                                      | <input type="checkbox"/> Allergies/hay fever                |
| <input type="checkbox"/> Urinary tract infection                                     | <input type="checkbox"/> Skin problems                      |
| <input type="checkbox"/> Growth delay or failure to thrive                           | <input type="checkbox"/> School problems                    |
| <input type="checkbox"/> Seizures  | <input type="checkbox"/> Discipline problems                |
| <input type="checkbox"/> Anemia (low blood count)                                    | <input type="checkbox"/> Sleep problems                     |
| <input type="checkbox"/> High lead level   | <input type="checkbox"/> Bed wetting/soiling                |
| <input type="checkbox"/> Chicken pox (if so, when did the child have this?<br>_____) | <input type="checkbox"/> Constipation                       |
| <input type="checkbox"/> Measles, mumps  | <input type="checkbox"/> Behavior or developmental problems |
| <input type="checkbox"/> Mononucleosis   | <input type="checkbox"/> Other: please explain:<br>_____    |

**For males:** Was the child circumcised? Yes No  
Is there any concern for undescended testicles? Yes No

**For females:** Has she started menstruating? Yes No      If yes, when? \_\_\_\_\_  
Are there any problems with periods?

**Please list information on any surgeries:**

Date: \_\_\_\_\_ Reason: \_\_\_\_\_ Hospital: \_\_\_\_\_

**Please list information on any other hospitalizations:**

Date: \_\_\_\_\_ Reason: \_\_\_\_\_ Hospital: \_\_\_\_\_

**Has the child ever had a blood transfusion?**  Yes  No      If yes, when? \_\_\_\_\_

**Please list child's prescribed medications and over-the-counter medications, such as vitamins and inhalers:**

Name of medication:	Strength/Dose	Frequency Taken
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**SOCIAL HISTORY, HEALTH HABITS, AND PERSONAL SAFETY**

**Exercise**       Sedentary (no exercise)    Mild exercise    Occasional vigorous exercise    Regular vigorous exercise

**Diet**      Was the child breastfed?  Yes  No  
Milk type: \_\_\_\_\_ Amt/day: \_\_\_\_\_  
Any dietary restrictions or allergies? Please explain.

**Caffeine**       None    Coffee    Tea    Cola  
How many cups/cans per day: \_\_\_\_\_

How many times has the child moved in past year?

Who lives in the house with the child?

Who participates in caring for child?

What school does the child go to?

Has the child ever been evaluated for special education services?

What activities does the child enjoy?

Do you have a religious affiliation? If so, what?

How often do you read to your child?

How often does your family eat meals together?

How often does your child use a carseat/booster seat?

Does your child use a bicycle or scooter? If yes, does s/he use a helmet?

Is your neighborhood safe?

Is the living situation stable and supportive?

Are there any smokers in the home?

Are there any guns in the home? If so, are they locked up?

In the past year, have you or the child ever felt threatened, controlled, physically hurt or made to feel afraid in your home?

Do you think you or the child will be unsafe when you go home today?

Is the child involved with any other agencies? If so, please list:

Family Health History			
Age	Significant Health Problems	Age	Significant Health Problems
Father		Grandfather	<i>Paternal</i>
		Grandmother	<i>Paternal</i>
Mother		Grandmother	<i>Maternal</i>
		Grandfather	<i>Maternal</i>
<b>Siblings</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	

**FAMILY HEALTH HISTORY:**

Does the child's mother, father, siblings, or grandparents have any of the following: **(if yes, who?)**

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure/high cholesterol _____ | <input type="checkbox"/> Kidney Disease _____                           |
| <input type="checkbox"/> Anemia _____                               | <input type="checkbox"/> Arthritis or Lupus _____                       |
| <input type="checkbox"/> Asthma/eczema/allergies _____              | <input type="checkbox"/> Miscarriages _____                             |
| <input type="checkbox"/> Cancer _____                               | <input type="checkbox"/> Learning disabilities _____                    |
| <input type="checkbox"/> Thyroid disease _____                      | <input type="checkbox"/> Vision or Hearing problems _____               |
| <input type="checkbox"/> Diabetes _____                             | <input type="checkbox"/> Nerve problems or seizure disorders _____      |
| <input type="checkbox"/> Lung problems _____                        | <input type="checkbox"/> Mental health issues or depression? _____      |
| <input type="checkbox"/> Heart problems _____                       | <input type="checkbox"/> Alcohol or drug problems? _____                |
| <input type="checkbox"/> HIV/AIDS _____                             | <input type="checkbox"/> Has the child ever been suicidal? _____        |
| <input type="checkbox"/> Tuberculosis _____                         | <input type="checkbox"/> Other medical or psychiatric conditions? _____ |
| <input type="checkbox"/> Stomach or intestinal disorders _____      | _____   |

### Other Problems

Check if the child has, or has had, any symptoms in the following areas to a significant degree and briefly explain if not addressed above

- |                                    |                                       |   |   |
|------------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> Skin      | <input type="checkbox"/> Chest/ Heart | <input type="checkbox"/> Other pain/ discomfort | <i>Recent changes in:</i>                 |
| <input type="checkbox"/> Head/Neck | <input type="checkbox"/> Back         | <input type="checkbox"/> Developmental          |   |
| <input type="checkbox"/> Ears      | <input type="checkbox"/> Intestinal   | or Behavioral Issues                            |   |
| <input type="checkbox"/> Nose      | <input type="checkbox"/> Bladder      |   |   |
| <input type="checkbox"/> Throat    | <input type="checkbox"/> Bowel        |   |   |
| <input type="checkbox"/> Lungs     | <input type="checkbox"/> Circulation  |   | <input type="checkbox"/> Weight           |
|                                    |                                       |   | <input type="checkbox"/> Energy level     |
|                                    |                                       |   | <input type="checkbox"/> Ability to sleep |

Do you have any questions or other information you would like to make sure the medical provider talks with you about today?

Date form originated: August 2008

Date form revised: July 2009 (format only)



## AUTHORIZATION FOR TREATMENT & HEALTH CENTER SERVICES

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ MR#: \_\_\_\_\_

The Community Health Center of Cape Cod strives to be a comprehensive health center, responding to community health needs, supporting long-term healing, and empowering individuals to manage their own health. We are committed to providing high quality, comprehensive, integrated health care to all patients we serve. Health Center providers and staff will make recommendations regarding your care and treatment.

I hereby authorize medical and/or dental treatment by Community Health Center of Cape Cod. I understand that medical treatment and procedures are provided by independent practicing physicians, nurse practitioners, physician assistants, dentists, or dental hygienists.

I agree to give the Health Center accurate information regarding medical services, physicians and facilities who are providing my care.

I agree to participate in the decisions regarding my care and follow recommendations of Community Health Center of Cape Cod, as agreed.

I agree to inform Community Health Center of Cape Cod regarding any changes in health and/or reactions to treatment and medications, including pain.

I retain the right to seek treatment elsewhere at my own expense.

I agree to provide Community Health Center of Cape Cod with insurance or financial information as requested, and will notify the Health Center of any changes in my insurance and financial circumstances.

I understand that in order to provide quality services, it may be necessary for Community Health Center of Cape Cod to communicate with and/or refer to outside resources. Communication between me and Health Center staff is confidential and release of any medical information must have my written permission. There are, however, legal limitations to this confidentiality. I have received a copy of Community Health Center of Cape Cod's Privacy Practices and understand my right to confidentiality.

I understand that I am responsible for all my personal effects during a health center visit.

I agree to treat Community Health Center of Cape Cod personnel with respect.

I understand that if medications are given to me through Community Health Center of Cape Cod, that they are not in childproof containers, and I agree that the Health Center will not be responsible for the safe storage of my medications.

The services of Community Health Center of Cape Cod and its professional staff are available only during posted clinic hours. Please refer to Off-Hours Policy posted in waiting area and Patient Information Guide.

Community Health Center of Cape Cod provides primary care, behavioral health and general dentistry. The ability to provide additional evaluation, such as laboratory and x-ray studies and specialty referrals and treatment is limited. More extensive studies and professional care will be the responsibility of the patient. Every attempt will be made to provide assistance with arranging such service.

I understand that if I have any questions or concerns about this form or any Health Center services or policies, I may ask to meet with any staff member during health center hours.

I agree to notify the Health Center within 24 hours if I am unable to keep my appointment.

Signature of Patient — \_\_\_\_\_ Date \_\_\_\_\_

