ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Today's Date (Fecha de hoy): _____

Patient Registration /*Registro de Paciente*

Legal Name (Nombre Legal):	**Birth Date (Fecha de Nacimiento):** / / (Month/Mes) (Day/Dia) (Year/Año)
Preferred Name (Nombre Preferido):	
Address (Dirección):	
Social Security Number (Número de Seguro Social): ☐ **No Social Security # (No # de Seguro Social)**	
Phone Numbers (Números de Teléfono) **Home (Casa):** **Cell (Cellular):**	**Email Address (Correo electrónico):**
Pharmacy Name (Nombre de su farmacia): **Address (Dirección):**	**Phone # (Teléfono):**
Gender (Género): ☐ Male (Hombre) ☐ Female(Mujer)	
Marital Status (Estado civil): ☐ Single (Soltero) ☐ Separated (Separado) ☐ Married (Casado) ☐ Divorced (Divorciado) ☐ Widowed (Viudo) ☐ Living together (Viviendo juntos)	
Country of Birth (País de nacimiento):	
Ethnicity (Etnicidad): ☐ Hispanic (Latino) ☐ Non-Hispanic (No Latino)	
Race (Raza) *Check all that apply (Marque todo lo que corresponda):	
☐ White (Blanco) ☐ Black/African American (Negro/Afroamericano) ☐ Asian (Asiático)	☐ American Indian/Alaskan Native (Indio Americano/Nativos de Alaska) ☐ Native Hawaiian (Nativo de Hawái) ☐ Other Pacific Islander (De otras islas del Pacífico)
Responsible Party (Persona responsable): ☐ Self (Mismo) ☐ Parent/Guardian (Padre/Guardian):	
Emergency Contact (Contacto de emergencia):	**Phone # (Teléfono):**
Is patient/parent/guardian employed? (¿Esta empleado el paciente/padre/guardián?) ☐ No ☐ Yes/Sí, $ _____Income (Ingresos) (Weekly/Semanal) (Monthly/Mensual) (Yearly/Anual)	
Spouse Employed? (¿Esta empleado su esposo/a?) ☐ No ☐ Yes/Sí, $ _____Income (Ingresos) (Weekly/Semanal) (Monthly/Mensual) (Yearly/Anual)	
Total Family Income (Ingreso Total Familiar) $ _____ ☐ N/A (Weekly/Semanal)(Monthly/Mensual)(Yearly/Anual)	**Family Size (Tamaño de Familia):** ___ Adults (Adultos) ___ Children (Niños)
Name of the children (Nombres de los niños):	

I certify that the above information is true and accurate to the best of my knowledge.
(Certifico que la infomación anterior es verdadera y correcta según lo entiendo.)

_____

Signature of Patient (Parent or Guardian) **Date (Fecha)**
Firma del paciente (Padre o guardián)

AUTHORIZATION AND INFORMED CONSENT

CONSENT FOR TREATMENT
I understand that by signing this agreement, I indicate my wish to receive health services from Zufall Health Center as determined by the provider(s). I understand that these services may be provided by, or with the assistance of, Medical Doctors, Podiatrists, Dentists, Advance Practice Nurses, Physician Assistants, Licensed Clinical Social Workers, Registered Nurses, Licensed Practical Nurses, and Medical/Dental Assistants. I do hereby consent to such treatment by the clinical staff as may be indicated to be the appropriate standard of care for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. I understand that if the provider determines that the recommended treatment cannot be provided by Zufall Health, I will receive the appropriate referral. I understand that no guarantees or assurances have been made to me concerning the results of the proposed care. Regarding reproductive health, I understand services are provided on a voluntary basis and that receipt of family planning services is not a prerequisite to receive any other services offered by Zufall. All services will be provided in a confidential manner.

PATIENT'S RIGHTS AND RESPONSIBILITIES & PRIVACY PRACTICES ACKNOWLEDGEMENT
The Patient's Bill of Rights and Responsibilities & the Notice of Privacy Practices was made available to me for review and a copy will be provided upon request. I understand Zufall Health may contact me by phone, email, or text message regarding coordination of my health care or other Zufall-sponsored activities. If I choose to opt-out of any of these methods of communication, it is my responsibility to notify a Zufall staff member.

RELEASE OF INFORMATION TO OTHER PROVIDERS OF SERVICE
I give my permission to Zufall Health Center to release necessary information concerning my illness and/or treatment to hospitals, physicians or medical agencies/institution, accrediting bodies or individuals, who provide me with health or social services and insurances or other payment agencies. I also give permission to my physician, hospitals and other agencies or individuals to release to Zufall Health Center any portion of my medical records or copies thereof that the health center requests.

CONSENT TO RETRIEVE PREVIOUS PRESCRIPTIONS
I give consent for Zufall Health Center to electronically retrieve any prescriptions that I have had filled by providers other than Zufall Health Center for the purpose of continuity of care and keeping all my medical records in my medical home. This will enable the provider to check for drug-to-drug interactions as well as having a complete and accurate medical record to optimize my medical care.

CERTIFICATON OF INFORMATION
I certify the information provided is true and accurate to the best of my knowledge. I acknowledge that my signature below is my consent for medical care, release of information, and retrieval of prescriptions as described above. A copy of this agreement shall be considered as effective and valid as the original.

_____ _____
Signature of patient age 13 and older Date
(For minors this consent only applies to reproductive and substance abuse services. Minor patients will be counseled about the importance of discussing health care concerns with a parent or other trusted adult.)

*The patient is: _____a minor _____ unable to sign. The above explanations have been made to, and consent has been given by, the patient's legal guardian, power of attorney, or closest available relative who is currently responsible for minor.

_____
Signature of parent/guardian or representative Relationship to patient Date
**(If patient is minor or unable to sign)*

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Authorization and Consent

Zufall Health Center at times may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages. Unless we have written permission to do so:

1. We will not leave messages with anyone except the patient or legal guardian.
2. We will not leave detailed messages on voice mail or answering machines.

Please read below and carefully consider who, if anyone, you want to have access to your medical information.

I, _____ give my permission for **Zufall Health Center** to leave phone messages regarding my medical care information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient name: _____
Date of Birth: _____

May we leave a phone message to inform you that test results are available and to contact our office for those results?

Home Number: _____ □ Yes □ No
Work Number: _____ □ Yes □ No
Cell Number: _____ □ Yes □ No

Who else may we share your test results with on your behalf?
Spouse/Partner: □ Yes □ No - If "Yes," name: _____
Son/Daughter: □ Yes □ No - If "Yes," name: _____
Other □ Yes □ No - If "Yes," name: _____

Patient Signature: _____ Date: _____

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Thank you for providing the following information in order for us to better serve you. All information will be kept confidential.

Do you think of yourself as:	**What is your current gender identity? (Check one):**
☐ Straight or heterosexual ☐ Lesbian, Gay, or homosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose	☐ Male ☐ Female ☐ Transgender Male (Female-to-Male) ☐ Transgender Female (Male-to-Female) ☐ Other ☐ Choose not to disclose

	YES	NO
Agricultural workers (and their family members)		
1. Have you or anyone living with you, such as a spouse or relative, worked in agriculture (on a farm, in a greenhouse or with livestock) in the U.S.A. in the past two years? (This does not include landscaping at private homes.)	☐	☐
2. Have you or any member of your household EVER worked in agriculture and stopped working in it because of age or disability?	☐	☐
3. In the past year have you travelled away from your home and stayed in temporary housing in order to work in agriculture?	☐	☐
Residents of Public Housing	**YES**	**NO**
1. Are you receiving, or have you received, a check from the government to help you pay your rent at any time in the past year?	☐	☐
2. Do you get assistance or a voucher, (like Section 8) to help you pay your rent?	☐	☐
3. Do you live in a subsidized housing building?	☐	☐
Housing Status	**YES**	**NO**
1. Do you live in a shelter or transitional housing now or did you within the past year?	☐	☐
2. Do you live with others, or rent a room in a house, to share expenses in what you consider a temporary basis until you can afford to move into a more permanent or more stable situation? (This does not include students sharing housing during the school year, or friends or relatives living together because they prefer that living arrangement.)	☐	☐
3. Are you staying at someone else's house, or moving among friends temporarily because you had to leave your home or apartment? (Sometimes called couch surfing)	☐	☐
4. Were you without a place to stay within the past year?	☐	☐
5. Have you received an eviction notice in the past year or were you at any time at risk of homelessness?	☐	☐
Veterans		
1. Have you served in the U.S. military or armed forces for any period of time?	☐	☐

Do you have an advance directive? ☐ Yes ☐ No

How did you hear about Zufall Health?

☐Self ☐Friend ☐Family ☐Other Zufall Patient ☐Community Agency ☐Internet ☐Hospital ☐Zufall Staff

☐Insurance ☐Event (Please specify):_____ ☐Other:_____

_____

Signature of Patient **Date**