NORTHEASTERN RURAL HEALTH CLINICS

Northeastern Rural Health Clinics (NRHC) is a federally and state funded community health center. Due to funding sources we must report certain data on our patient population, including ethnicity (race), income information and resident status. No individual information or patient names are included in our data reporting. We thank you for your assistance in supplying this information. This information is kept strictly confidential and is used for data purposes only to help us continue to receive funding to serve you better.

HAVE YOU EVER BEEN SEEN AT ANY OF NORTHEASTERN'S CLINICAL SITES? ☐ YES ☐ NO

Patient Legal Name: Last:_____ First:_____ Middle:_____

Previous Names Used:_____ Nickname or Alias:_____

Sex: ☐ Male ☐ Female **DOB**:_____ **Age**:_____ **SSN#:**_____

Sexual Orientation (check one): ☐ Homosexual (Lesbian, gay) ☐ Heterosexual (Straight) ☐ Bisexual

☐ Don't Know ☐ Choose not to disclose

Something else (please describe):_____

Gender Identity (check one): ☐ Male ☐ Female ☐ Transgender (Female to Male) (Male to

Female) ☐ Non-Conforming (neither exclusively male or female)

Assignment at Birth (check one): ☐ Male ☐ Female ☐ Unknown ☐ Choose not to disclose

Preferred Pronoun (check one): ☐ He/Him ☐ She/Her ☐ They/Them

Mailing Address:_____

City: State: Zip:

Physical Address (if different):_____

City: State: Zip:

Home Phone:_____ **Mobile Phone:**_____ **Work Phone:**_____

Email Address:_____ Would you like to sign up for Patient Portal? ☐ Yes ☐ No

Do you give NRHC consent to send automated text alerts on your mobile phone regarding appointments? ☐ Yes ☐ No

Do you give NRHC consent to disclose childhood immunization to CAIR? ☐ Yes ☐ No

Primary Physician:_____

Primary Dentist: _____

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Preferred Language (check one): ☐ English ☐ Spanish ☐ Other: _____

Ethnicity (check one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (check one): ☐ White ☐ Asian ☐ Pacific Islander ☐ Alaskan Native ☐ American Indian

☐ Native Hawaiian or Other Pacific Islander ☐ Black or African ☐ Black or African

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Would you like to receive a Patient Care Summary after visits? ☐ Paper Print Out ☐ Patient Portal ☐ No Thanks

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Number of persons in the household: ☐

Would you like to apply for our Sliding Fee Discount Program? ☐ Yes ☐ No

Income level: (please circle your approximate annual gross household income)

$12,000	$16,000	$20,000	$24,000	$28,000
$32,000	$36,000	$40,000	$44,000	$48,000
$52,000	$56,000	$60,000	$64,000	$68,000
$72,000	$76,000	$80,000	$84,000	$88,000
$92,000	$96,000	$100,000	$104,000	$108,000
$112,000	$116,000	$120,000	$124,000	$128,000
$132,000	$136,000	$140,000	$114,000	$148,000
$152,000	$156,000	$160,000	$164,000	$168,000

****For more information, or if you have special circumstances, please ask receptionist/front desk****

Migrant Worker: ☐ None ☐ Migrant ☐ Not a Farm Worker ☐ Seasonal

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Resident Status: This information is for data purposes only, please check one:

☐ Not Homeless ☐ Doubling Up ☐ Homeless ☐ Shelter

☐ Transitional ☐ Street ☐ Other:_____

Are you a Veteran? Yes No | **Public Housing:** ☐ No ☐ Other ☐ Public Housing ☐ Tenant Based Voucher

Payment Information: Circle one and present documentation to Front Desk:

☐ Self-pay ☐ Medi-Cal ☐ Insurance ☐ Medicare ☐ Sliding Fee ☐ Other:_____

Name of Insurance: _____

Responsible Party Information: (If Different from Patient It Must Be Filled out)

Legal Name:_____

First: MI: Last:

Mailing Address:_____

City: State: Zip:

Physical Address (if different):_____

City: State: Zip:

Date of Birth:_____ **SS#:**_____ **Phone #:**_____

Employment: _____ **Gender:** _____ **Email:** _____

Relationship to Patient: (Check one):

□ Self – Patient is the insured □ Spouse – Patient is the spouse of the insured

□ Natural Child – Insured has financial responsibility □ Natural Child – Insured does not have financial responsibility

□ Parent □ Grandparent □ Step Child □ Foster Child □ Grandchild □ Niece/Nephew

□ Other: _____

Emergency Contact:_____**Relationship:**_____**Phone #:**_____

Support person/Caregiver:_____**Relationship:**_____**Phone #:**_____

Role: □ Caregiver □ Emergency Contact □ Next of Kin □ Guardian □ Other: _____

Place of Employment:_____**Occupation:**_____**Phone #:**_____

Preferred Pharmacy:_____**Preferred Lab/Draw Station:**_____

☐ **I Decline to participate in the sure scripts import of my medication History.**

The below person(s) have my permission to speak to NRHC regarding my appointments and treatment.

Name:	Relationship:	Phone #:

Initial Below:

_____If a referral is required from my visit today or in the future; it is ok to leave a message on my Phone or with the above person(s) regarding appointment information.

Comment:_____

_____It is okay to call and confirm appointments and leave a message on the machine or with the person who answers the phone.

Comment:_____

_____It is okay to call and leave a message for me to call provider regarding my labs or test results.

Comment:_____

Date:_____ **Time:**_____ AM / PM

Signature: _____

(Patient or Legal Representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____

(Patient or Legal Representative)

PAYMENT & TREATMENT AGREEMENT

By signing below, I agree to and authorize the following:

- All the information I have provided on this "Patient Information Sheet" is true.
- I authorize the staff of Northeastern Rural Health Clinics (NRHC) to treat, test, and examine myself and any children/family member listed in the information I have provided.
- I authorize assignment of benefits (payments from a third party) for medical service to be paid to NRHC.
- I agree that I will receive a bill and pay the cost for services not covered by my health insurance or reimbursed by other funding programs.
- I understand use of any medical insurance or state funding means that NRHC may release information to the insurance company or the State of California about my medical diagnosis and care.
- I understand that NRHC uses outside laboratories for some of their tests.
- I understand that I may receive a bill from an outside laboratory if my insurance does not cover the cost of the test.

Date:_____ **Time:**_____ AM / PM

Signature: _____

(Patient or Legal Representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____

(Patient or Legal Representative)

Witness Signature:_____ **Title:** _____

NORTHEASTERN RURAL HEALTH CLINICS

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

Acknowledgement of Receipt:

By signing this form, you acknowledge either receipt of the "Notice of Privacy Practices" of Northeastern Rural Health Clinics, or that you have read a copy of the "Notice of PrivacyPractices" of Northeastern Rural Health Clinics. Our "Notice of Privacy Practices" providesinformation about how we may use and disclose your protected health information. Weencourage you to read it in full.

Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtaina copy of the revised notice from one or our Patient Support Coordinators.
If you have any questions about our "Notice of Privacy Practices", please contact the Privacy Officerat (530) 251-1454.

Initial Below:

_____ I acknowledge receipt of a copy of the "Notice of Privacy Practices" of Northeastern RuralHealth Clinics.

_____ I acknowledge that I have read a copy of "Notice of Privacy Practices" of Northeastern RuralHealth Clinics.

Date:_____Time:_____AM / PM

Signature: _____

(Patient or Legal Representative)

If signed by someone other than the patient, indicate relationship: _____

Print Name: _____

(Patient or Legal Representative)

NORTHEASTERN RURAL HEALTH CLINICS

This notice is to advise all patients of our existing “No Show” policy and payment policy.

No Show Policy:

Our goal at Northeastern is to provide the best services to our community. When an appointment is missed it keeps another patientfrom being seen in a timely manner. With the number of “No Show” patient appointments on the rise, ***we require*** a 24-hour notice if youare unable to make your scheduled appointment. We will allow voicemail cancellations as long as they are received before the office opens at 7:00 a.m. After repeated no show appointments, future scheduled appointments will be at the discretion of your provider. You may be receiving a letter outlining your future appointments signed by your provider or the Medical Director. As an alternative youcan elect to be seen as a walk in patient in Urgent Care (with the exception of those seeking refills on prescriptions).

Payment Policy:

All payments, including co-pay, are due at the time of service. If you are unable to make a payment at the time of visit, your appointment may be rescheduled.

We appreciate your understanding concerning this matter and with your cooperation we will be able to continue providing our community with the many services we offer.

Patient Name: _____

Signature: _____

Date: _____

Staff Initials: _____

Dental Health History

Name: _____ Birthdate: _____

Please answer each question by checking **yes** or **no**. If in doubt, leave blank.

Why are you now seeking dental treatment? _____

	YES	NO
Are you in good health?		
Are you now under the care of a physician?		
If so, for what condition?		
Have you ever been hospitalized or had a serious illness?		
If **yes** please explain:		

	YES	NO
Have you ever had excessive bleeding, following an extraction or do cuts take longer to heal now than previously?		
Women - Are you pregnant? Give due date.		
Do you smoke? How much?		

Have you ever had any of the following:

	YES	NO		YES	NO
Sinus problems			Stroke		
Headaches			Convulsions/epilepsy		
Tuberculosis			Emphysema		
Rheumatic fever			Heart murmur		
Chest pain/discomfort			Heart attack/trouble		
Shortness of breath			Heart disease		
High blood pressure			Congenital heart disease		
Artificial heart valve			Pacemaker		
Diabetes			Arthritis/rheumatism		
Artificial joints			Hepatitis		
Jaundice			Kidney disease		
Venereal disease			Bleeding tendency		
Blood transfusions			Radiation therapy		
Cancer			Bisphosphonate therapy		
HIV			Asthma		

Are you allergic to or have you ever had a reaction to any of the following:

	YES	NO		YES	NO
Local anesthetics			Dyes or flavoring		
Barbiturates			Sleeping pills		
Sedatives			Penicillin/antibiotics		
Aspirin/codeine			Sulpha drugs		
Shellfish			Other		

Continued on back☞

Are you presently taking any of the following medications?					
	YES	**NO**		**YES**	**NO**
Antibiotics/sulpha			Blood thinners		
Blood pressure medication			Thyroid medicine		
Cortisone/steroids			Digitalis/heart medication		
Nitroglycerin			Aspirin		
Bisphosphonates			Inhalers		

Please list all medications and dosages you are currently taking (or within the past 2 years):

1.
2.
3.
4.

Is there any disease, condition or problem not listed above that you think we should know about or any activity your doctor says you cannot do?____ **YES** ____ **NO**

Please explain:

Physician's name: Phone #

Have you ever had any serious trouble associated with any previous dental treatment?

____ **YES** ____ **NO**

If so, please explain:

Date of last dental visit: Dental x-ray:

Which do you use?					
	YES	**NO**		**YES**	**NO**
Brush			Fluoride rinse		
How often?			Other		
Dental floss					
How often?					

Signature of patient or parent Date