Unicare Community Health Center Patient Registration

UCHC/Pt. Reg., May 2020

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City Zip

Phone #: ( ) _____ ( ) _____ ( ) _____
Home Work Cellular

Do you have a **Social Security Number?** ☐ Yes ☐ No Social Security Number: _____

Is your Social Security # for employment only? ☐ Yes ☐ No Email Address: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Month / Day / Year

Homeless? ☐ Yes ☐ No

Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter ☐ Transitional ☐ Street ☐ Permanent Supportive Housing ☐ Other

Are you a Veteran? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Are you disabled? ☐ Yes ☐ No

Smoke? ☐ Yes ☐ No

Sexual orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Do not wish to disclose

Ethnicity: ☐ Non-Latino/ Hispanic ☐ Latino/ Hispanic

Race: ☐ White ☐ Asian ☐ African American ☐ American Indian ☐ Pacific Islander ☐ Native Hawaiian ☐ More than 1 race ☐ Refuse to report

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Do not wish to disclose

Education level completed: ☐ Less than high school graduate ☐ High school graduate ☐ Some College/Associate degree ☐ Bachelor's degree or higher

Are you an agricultural worker? ☐ Yes ☐ No

If yes, are you seasonal or migrant? ☐ Seasonal ☐ Migrant

Is one of your family members an agricultural worker? ☐ Yes ☐ No

If yes, which type? ☐ Seasonal ☐ Migrant

Number of people in your family household: _____ **Annual family income:** $ _____

What language should your information be provided in? _____

How well do you understand English? ☐ Very well ☐ Moderate ☐ Very little ☐ None

Do you have any allergies? _____

Friend or Relative to Contact In Case of Emergency: _____ ( )
(Name) (Relationship) (Telephone #)

If minor, mother's name: _____ If minor, father's name: _____

How did you hear of the Clinic UCHC? _____

1. Do you have health insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____

2. Do you have dental insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____

3. Do you have Medi-Cal? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy #: _____

4. Does your child (patient) have CHDP? ☐ Yes ☐ No **5.** Do you have FPACT? ☐ Yes ☐ No

I understand that health information is confidential. I authorize the exchange of information between UCHC and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available upon request. I authorize to receive any and all services provided by UCHC, including but not limited to: Primary Care, Dental, Behavioral, Substance Use and Psychiatric services.

I hereby authorize treatment by UCHC. ☐ Yes ☐ No Initials _____

The exchange of information may include treatment for:

Alcohol or drugs- ☐ Yes ☐ No Initials _____ Psychiatric drugs- ☐ Yes ☐ No Initials _____

Adequate numbers of radiographs are required for proper diagnosis.
I consent to performing radiographs as needed for my dental treatment: ☐ Yes ☐ No Initials _____

Patient Signature or guardian (if minor): _____ **Date** _____

Name and relationship (if not patient) _____

MISSION STATEMENT / *DECLARACION DE MISSION*:

The mission of Unicare is to be a community health care organization that treats everyone with dignity, respect and cultural sensitivity to help create an environment in which all can prosper.

La misión de Unicare es ser una organización de salud comunitaria que trata a todos con dignidad, respeto y sensibilidad cultural para ayudar a crear un ambiente en el que todos puedan prosperar.

NOTICE OF PRIVACY PRACTICES
NOTIFICACIÓN DE PRACTICAS DE PRIVACIDAD

I hereby acknowledge that a copy of Unicare Community Health Center, Inc.'s "Notice of Privacy Practices." is posted in the waiting area and I further understand that I can request a copy at any time if I wish in the language that I prefer.

Recibí una copia de la "Notificación de Prácticas de Privacidad" de Unicare Community Health Center, Inc. Reconozco que una copia de la "Notificación de la Privacidad" se puede encontrar en la sala de espera, y además entiendo que puedo solicitar una copia en cualquier idioma en el momento que deseo.

PATIENT NAME/*NOMBRE DEL PACIENTE*

DATE OF BIRTH/*FECHA DE NACIMIENTO*

SIGNATURE OF PATIENT OR LEGAL GUARDIAN/*FIRMA DEL PACIENTE O TUTOR LEGAL*

DATE/*FECHA*

UNICARE COMMUNITY HEALTH CENTER, INC.
ACKNOWLEDGEMENT/ *RECONOCIMIENTO*

PATIENT NAME / *NOMBRE DEL PACIENTE* _____ DOB / *FECHA DE NACIMIENTO* ____/____/____

ADDRESS / *DIRECCIÓN* _____

CITY / *CUIDAD* _____ STATE / *ESTADO* _____ ZIP CODE / *CÓDIGO POSTAL* _____

TELEPHONE / *NO. DE TELÉFONO* (_____) _____ – _____

ADVANCE DIRECTIVE / *DIRECTIVA ANTICIPADA*

I acknowledge that the physician or one of his / her staff members have provided me with information regarding Advance Directive.

Reconozco que el médico o uno de sus miembros del personal me han proporcionado información con respecto a la Directiva Anticipada.

1. I am 18 years old or older. (Check one) ☐ YES / *SI* ☐ NO

1. Tengo 18 años o más. (Marque uno)

2. I realize that I have the option of putting together Advance Directive for my healthcare. My physician has provided me with written information concerning Advance Directive. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advance Directive.

2. Reconozco que tengo la opción de elaborar una directiva anticipada para mi atención médica. Mi médico me ha proporcionado información por escrito sobre la Directiva Anticipada. Entiendo que es mi responsabilidad proporcionar a mi (s) doctor (es) con cualquier documento que se requiera para llevar a cabo mi Directiva Anticipada.

3. I am aware that Advance Directive may be one of the following:

3. Estoy consciente de que la Directiva Anticipada puede ser una de las siguientes:

a) A Durable Power of Attorney for healthcare.
a) Un Poder Notarial Duradero para el cuidado de la salud.

b) The Declaration in the A Natural Death Act – Ex. A Living Will.
b) La Declaración en la Ley de muerte natural - Ex. Un Testamento Vital.

c) I may write down my wishes on a piece of paper, so that my family may use the document in deciding my medical treatment in the event I am unable to do so.
c) Puedo anotar mis deseos, para que mi familia pueda usar el documento para decidir mi tratamiento médico en caso de que yo no pueda hacerlo.

PATIENT SIGNATURE / *FIRMA DEL PACIENTE* _____ DATE / *FECHA* _____

THIS DOCUMENT WILL BECOME PART OF MY MEDICAL RECORD.
ESTE DOCUMENTO SE HARÁ PARTE DE MI REGISTRO MÉDICO.

ADULT HEALTH HISTORY:

Name/Nombre:	Age/Edad:	D.O.B./Cuando Nacio:	Date/Fecha:

HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion.....	No	Yes/Si	Rheumatic fever/Fiebre Reumatica.....	No	Yes/Si
Mumps/Paperas.....	No	Yes/Si	Heart Disease/Enfermedad del Corazon.....	No	Yes/Si
Chickenpox/Viruela.....	No	Yes/Si	Tuberculosis.....	No	Yes/Si
Diabetes.....	No	Yes/Si	Venereal Disease/Enfermedad Veneria.....	No	Yes/Si
Strokes/Embolio.....	No	Yes/Si	Serious Disease/Enfermedad Graves.....	No	Yes/Si

Ever hospitalized/Ha sido hospitalisado..... No Yes/Si Explain/Explicacion_____
Ever had surgery/Ha tenido operaciones..... No Yes/Si Explain/Explicacion_____
Had broken bones/Ha tenido fracturas..... No Yes/Si Explain/Explicacion_____
Head concusiions or injuries/Glopes o Heridas de cabeza..... No Yes/Si Explain/Explicacion_____
Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetno_____
Date of Last PAP Smear/La Fecha de papanicolou exam de cancer_____
Date of Last Mammogram/Mammographia_____

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer..... No Yes/Si Who/Quien?_____
Diabetes..... No Yes/Si Who/Quien?_____
Tuberculosis..... No Yes/Si Who/Quien?_____
Heart trouble/Enfermedad del Corazon..... No Yes/Si Who/Quien?_____
High blood pressure/Presion alta..... No Yes/Si Who/Quien?_____
Stroke/Embolio..... No Yes/Si Who/Quien?_____
Convulsions/Epilepcia..... No Yes/Si Who/Quien?_____
Suicide/Suicidio..... No Yes/Si Who/Quien?_____

SOCIAL HISTORY/HISTORIA SOCIAL:

☐ Single/Soltero ☐ Married/Casado ☐ Separated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo
Alcoholic Beverages/Bebidas Alcolicas: ☐ Never/Nunca How much/Cuanto_____
Tobacco or Cigarettes/Tobacco o Cigarillos: ☐ Never/Nunca How much/Cuanto_____
Are you sexually active?/Este sexualmente activa? ☐ Yes ☐ No
What is your job?/Cual es su trabajo?_____
Education Level/Nivel de Education: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 College/Colegio Supenor: ☐ 1 ☐2 ☐3 ☐4
Race/Raza: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐American Indian ☐White ☐African American ☐More than 1 Race ☐Other
Ethnicity/Étnicidad: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Primary language (lenguaje primario)_____ Secondary language (lenguaje secundaria)_____

SYSTEMIC REVIEW GENERAL? REVISION DE SYSTEMAS:

Recent weight change?/Reciente cambio de peso?..... No Yes/Si
Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?..... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel..... No Yes/Si Explain/Explicacion_____
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nanz-Garganta..... No Yes/Si Explain/Explicacion_____
Neck/Cuello..... No Yes/Si Explain/Explicacion_____
Lungs/Pulmones..... No Yes/Si Explain/Explicacion_____
Heart and Circulation/Corazon o Circulacion.... No Yes/Si Explain/Explicacion_____
Blood/Sangre..... No Yes/Si Explain/Explicacion_____
Emotions/Emociones..... No Yes/Si Explain/Explicacion_____
Nerves/Nervios..... No Yes/Si Explain/Explicacion_____
Muscles and Bones/Estomago o Intestinos..... No Yes/Si Explain/Explicacion_____
Sex Organs/Organos Sexuales..... No Yes/Si Explain/Explicacion_____
Urinary/Unnanos..... No Yes/Si Explain/Explicacion_____
Any other/Cualquiera otro..... No Yes/Si Explain/Explicacion_____

ALLERGIES OR REACTIONS TO FOOD/MEDICATION/LATEX? (ALLERGIAS O REACIONES A ALIMENTOS/MEDICINAS/LATEX?)
_____
If applicable, list all current medications (lista de medicamentos actuales)_____
_____

PATIENT SIGNATURE/FIRMA_____ DATE/FECHA_____

DOCTOR SIGNATURE/FIRMA_____ DATE/FECHA_____

UNICARE COMMUNITY HEALTH CENTER

ADULT TUBERCULOSIS RISK ASSESSMENT

EVALUACIÓN DE RIESGO DE TUBERCULOSIS PARA ADULTOS

You may be at increased risk for TB if you answer YES to any of the following questions: *Usted puede estar en mayor riesgo de TB si responde SÍ a cualquiera de las siguientes preguntas:*	**DATE / *FECHA*** / /

1. Do you have a family member or close contact with history of confirmed or suspected TB? *¿Tiene un familiar o un contacto cercano con historial médico de TB confirmada o sospechada?*	**YES / *SI*** ☐	**NO** ☐
2. Are you from Asia, Africa, Central America or South America? (These areas have a higher prevalence of TB.) *¿Es usted de Asia, de África, de Centroamérica o de Suramérica? (Estas áreas tienen una mayor prevalencia de TB).*	**YES / *SI*** ☐	**NO** ☐
3. Do you live in an "out of home" placement facility? *¿Vive en una instalación de colocación "fuera de casa"?*	**YES / *SI*** ☐	**NO** ☐
4. Do you have a history of confirmed or suspected HIV infection? *¿Tiene historial médico de infección por VIH confirmada o sospechada?*	**YES / *SI*** ☐	**NO** ☐
5. Do you live with any individual who is HIV positive? *¿Vive usted con alguna persona que sea VIH positivo?*	**YES / *SI*** ☐	**NO** ☐
6. Have you been, or do you live with any individual who has been incarcerated in the last 5 years? *¿Ha estado, o vive con algún individuo que ha estado encarcelado en los últimos 5 años?*	**YES / *SI*** ☐	**NO** ☐
7. Do you live among, or are you frequently exposed to individuals who are homeless, migrant farm workers, users of street drugs, or resident in a nursing home? *¿Vive usted o está frecuentemente expuesto a personas sin hogar, trabajadores agrícolas migratorios, usuarios de drogas de la calle o residentes en un asilo de ancianos?*	**YES / *SI*** ☐	**NO** ☐

*A person who is at increased risk for TB should have a yearly TB test.

* *Una persona que está en mayor riesgo de tuberculosis debe tener una prueba anual de TB.*

NAME / *NOMBRE* _____ DATE / *FECHA* _____

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other (*Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

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