Broad Top Health & Wellness

BTAMC Inc.

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

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As a Federally Qualified Health Center (FQHC), we are required to collect the following information on all the patients we serve. Per federal privacy rules (HIPAA) protected information is kept confidential and is not disclosed, unless authorized by the patient. Thank you for your cooperation and choosing BTAMC as your health care provider.

PLEASE PRINT THE INFORMATION, BELOW.

TODAY'S DATE: _____ **DATE OF BIRTH:** _____ **SEX:** _____M _____F

PATIENT FULL NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

EMAIL: _____ (please circle) **I DO / I DON'T** authorize BTAMC to leave a detailed message

MARITAL STATUS: _____Single _____Married ____Domestic Partner _____Divorced _____Separated _____Widowed

PRIMARY LANGUAGE: (please circle) ENGLISH SPANISH SIGN LANGUAGE OTHER: _____

ETHNICITY: (please circle) LATINO/HISPANIC NON-LATINO/HISPANIC NOT REPORTED/REFUSED

RACE: CAUCASIAN AFRICAN AMERICAN ASIAN AMERICAN INDIAN/ALASKA NATIVE HAWIIAN/PACIFIC NATIVE

BI-RACIAL or OTHER: _____

FINANCIAL RESPONSIBILITY (Guarantor) & INSURANCE INFORMATION (Please provide insurance cards)

Relationship to Patient: _____Self/Same as Patient _____Spouse/Partner _____Parent OTHER: _____

Guarantor's Name: _____

Guarantor's Address: _____

Guarantor's PHONE: _____ **Guarantor's CELL:** _____ **SEX:** _____M _____F

Patient's Insurance: _____ **Insurance ID#:** _____

Guarantor/Policy Holder: _____ **Insurance Group#:** _____

Guarantor's Date of Birth: _____ **Subscriber's Social Security#:** _____

Pharmacy: _____ **Mail Order Pharmacy:** _____

PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME LEVEL

We ask income information because we receive federal funding for assistance programs that benefit patients with lower incomes.

Family Size	From To	From To	From To	From To	From To	Above
1	$0 - $12,880	$12,881 - $16,100	$16,101 - $19,320	$19,321 - $22,540	$22,541 - $26,760	$26,761 +
2	$0 - $17,420	$17,421 - $21,775	$21,776 - $26,130	$16,131 - $30,485	$30,486 - $34,840	$34,841 +
3	$0 - $21,960	$21,961 - $27,450	$27,451 - $32,940	$32,941 - $38,430	$38,431 - $43,920	$43,921 +
4	$0 - $26,500	$26,501 - $32,751	$32,752 - $39,750	$39,751 - $46,375	$46,376 - $53,000	$53,001 +
5	$0 - $31,040	$31,040 - $38,800	$38,801 - $46,560	$46,561 - $54,320	$54,321 - $62,080	$62,081 +
6	$0 - $35,580	$35,581 - $44,475	$44,476 - $53,370	$53,371 - $62,265	$62,266 - $71,160	$71,161 +
7	$0 - $40,120	$40,121 - $50,150	$50,151 - $60,180	$60,181 - $70,210	$70,211 - $80,240	$80,241 +
8	$0 - $44,660	$44,661 - $55,825	$55,826 - $66,990	$66,991 - $78,155	$78,156 - $89,320	$89,321 +

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The data you provide is for continued grant funding and your personal information is not reported.
You may choose not to disclose some information, below. Please select "Not Reported/Refused".
Thank you for your cooperation and choosing BTAMC as your health care provider.

Education Completed: _____ High School/GED _____ Some College/Trade School _____Business School/College Degree

Employment Status: _____Yes/Full-time _____Yes/Part-time _____No _____No/Retired _____ I am a Military Veteran

_____Self Employed _____I am a Migratory Worker with a Residence _____I am a Seasonal Worker without a Residence

Shelter Status: _____Public Housing _____Doubling-up/Transitional _____Shelter _____Street _____Not Homeless

Student Status: _____Full-time _____Part-time **Sex at Birth:** _____M _____F _____Not Reported/Refused

Gender Identity: _____M _____F _____Transgender Female to Male _____Transgender Male to Female _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

Sexual Orientation: _____Heterosexual/Straight _____ Homosexual/Lesbian/Gay _____Bisexual _____Other

_____Uncertain/Don't Know _____Not Reported/Refused

EMERGENCY CONTACTS & CONSENT TO SHARE PERSONAL HEALTH INFORMATION

Relationship to Patient: _____Spouse/Partner _____Parent/Legal Guardian _____Child _____Other

Contact's Name: _____

Contact's PHONE: _____ **Contact's CELL:** _____ **OTHER:** _____

I authorize BTAMC to share my personal health information with the named persons, as designated below.

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

Name:_____ **PHONE:** _____ **Relationship:** _____

_____Medical _____Billing _____Scheduling _____All

TREATMENT & PAYMENT AUTHORIZATION

I authorized treatment for myself, or the identified minor patient. I agree to participate in clinical assessment, treatment and testing as a patient of BTAMC. I understand examination and treatment may be from providers such as, physicians, physician's assistants, nurse practitioners, clinical social workers, interns or students under supervision of a doctor, or other, licensed professionals. I authorize BTAMC to release my medical information needed in the continuum of care with other medical providers or facilities.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not they are covered by insurance. I understand that I may set up payment arrangements with the billing department for charges not covered by insurance. I authorize the release of medical information needed to determine insurance benefits.

As a courtesy, BTAMC will submit claims to an insurance company on my behalf. I understand charges not covered by insurance such as, co-pays, deductibles or sliding fees are my responsibility. Any returned checks by my financial institution will incur a $25.00 fee.

PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

STAFF WITNESS: _____ **DATE/ENTRY:** _____

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We would like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health care needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

◆ Please briefly state in the box below the reason for your visit ◆

How did you hear about our practice?

◆ Review of Systems ◆

Please review the following symptoms and circle those items that are a problem for you.

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

◆ Past Medical History ◆

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Usual Childhood Disease (Mumps, Measles, Chicken Pox)		❑ Cancer Type: Location:	
❑ **Covid-19 / SARS-CoV-2**		❑ Bleeding Problems / Hemophilia / Anemia	
❑ Hypertension		❑ Brain Injury / Brain Malformation	
❑ High Cholesterol		❑ Epilepsy / Seizures	
❑ Hypothyroid (low) or Hyperthyroid (high)		❑ Depression / Anxiety / Nervousness	
❑ COPD, Emphysema or Asthma		❑ Mental Disorder / Behavioral Problem	
❑ Respiratory Disease / TB		❑ Dementia / Alzheimer's Disease	
❑ Diabetes		❑ MS / ALS / Parkinson's Disease	
❑ GERD / Ulcers / Stomach Problems		❑ Arthritis / RA / Lupus	
❑ Heart Disease / Mitral Valve Prolapse		❑ Hepatitis / Liver Disease	
❑ Blood Clot / DVT / Pulmonary Embolus		❑ Kidney Disease	

◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆

Operation / Hospitalization / Injury	Month / Yr.	Operation / Hospitalization / Injury	Month / Yr.

◆ Other Physicians and Specialists ◆

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

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Medication or Food Allergies or Intolerances

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

Medications, Vitamins and Herbal Supplements

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

	Month / Yr.		Month / Yr.		Month / Yr.
COVID-19 Vaccine		Mammogram		Endoscopy (EGD)	
Flu Vaccine		Pap Smear		Stent Placement	
Pneumonia Vaccine		Prostate Exam		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Heart Stress Test	
Hepatitis B Vaccine		Bone Density		Echocardiogram	
Shingles Vaccine		Eye Exam		EKG	
Gardasil Vaccine		Foot Exam		**Most Recent Lab Work**	

Family Health History

Please list below the health history of your genetic (blood) relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Paternal Grandfather:				
Paternal Grandmother:				
Maternal Grandmother:				
Paternal Grandmother				
Father:				
Mother:				
Sibling:				
Sibling:				
Children:				

Social History

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

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