



Broad Top Health & Wellness

BTAMC Inc.

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

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 - \$13,590	\$13,591 - \$16,987	\$16,988 - \$20,385	\$20,386 - \$23,782	\$23,783 - \$27,180	\$27,181 +
2	\$0 - \$18,310	\$18,311 - \$22,887	\$22,888 - \$27,465	\$27,466 - \$33,042	\$33,043 - \$36,620	\$36,621 +
3	\$0 - \$23,030	\$23,031 - \$28,787	\$28,788 - \$34,545	\$34,546 - \$40,302	\$40,303 - \$46,060	\$46,061 +
4	\$0 - \$27,750	\$27,751 - \$34,687	\$34,688 - \$41,625	\$41,626 - \$48,562	\$48,563 - \$55,500	\$55,501 +
5	\$0 - \$32,470	\$32,471 - \$40,587	\$40,588 - \$48,705	\$48,706 - \$56,822	\$56,823 - \$64,940	\$64,941 +
6	\$0 - \$37,170	\$37,171 - \$46,487	\$46,488 - \$55,785	\$55,786 - \$65,082	\$65,083 - \$74,380	\$74,381 +
7	\$0 - \$41,910	\$41,911 - \$52,387	\$52,388 - \$62,865	\$62,866 - \$73,342	\$73,343 - \$83,820	\$83,821 +
8	\$0 - \$46,630	\$46,631 - \$58,287	\$58,288 - \$69,945	\$69,946 - \$81,602	\$81,603 - \$93,260	\$93,261 +



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Thank you for your cooperation and choosing BTAMC as your health care provider. **PLEASE CIRCLE YOUR ANSWER**

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

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. 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 for the continuum of care with other medical providers and facilities, or with payors to determine insurance benefits.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. 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, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a \$25.00 charge.

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

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

"The mission of Broad Top Area Medical Center, Inc. is to provide access to affordable, high-quality care without discrimination."



◆ 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 Grandfather:				
Maternal 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		