Elica Health Centers

PATIENT REGISTRATION

Today's Date (month/day/year)	**Preferred Name**	
First Name	**Last Name**	
Social Security Number	**Date of Birth** (month/day/year)	
Home Address		
City	**State**	**Zip Code**
Phone Number	**Alternate Phone Number**	
Email Address		

Patient Demographics

Legal Sex ☐ Female ☐ Male ☐ Nonbinary ☐ Unknown ☐ X

Gender Identity

☐Female ☐ Male ☐ Non-Binary / Genderqueer
☐Transgender Male / Trans Man / FTM
☐Transgender Female / Trans Woman / MTF ☐ Questioning
☐Two Spirit ☐ Other ☐ Choose Not To Disclose

Sexual Orientation

☐Straight or Heterosexual
☐Lesbian
☐Gay
☐Bisexual
☐Asexual
☐Omnisexual
☐ Pansexual
☐ Queer
☐ Something Else
☐ Don't Know
☐ Choose Not to Disclose / Decline

Patient's Sex Assigned at Birth

☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Not Recorded on Birth Certificate ☐ Choose Not To Disclose

Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

What is your ethnicity?

☐ Non-Hispanic or Latino/a ☐ Mexican, Mexican American, or Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Don't Know
☐ Another Hispanic, Latino/a or Spanish Origin ☐ Multiple Hispanic, Latino/a or Spanish Origins ☐ Choose Not To Disclose

What is your race or biological family background?

☐ White ☐ Black/African American ☐ Alaska Native ☐ American Indian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Guamanian or Chamorro ☐ Native Hawaiian ☐ Samoan ☐ Other Pacific Islander
☐ Choose Not To Disclose ☐ Don't Know

Emergency Contact

Name

Phone Number | **Relationship to Patient**

Employment

Employment Status ☐ Full time ☐ Part time ☐ Unemployed

Language

Do you need an interpreter? ☐ Yes ☐ No

Do you speak English? ☐ Yes ☐ No
My preferred language is _____

English Fluency ☐ Excellent ☐ Very Good ☐ Good ☐ Not Good ☐ Not at All

Preferred Written Language | **Preferred Language Spoken**

Additional Demographics

Are you experiencing homelessness?

☐ Yes ☐ No (Not Homeless) ☐ Currently Not Homeless (was in the last 12 months)

If Yes, please choose one (1) below

☐ Living in Shelter (Homeless Shelter) ☐ Transitional Housing ☐ Living with Others (Doubling Up) ☐ Street, Camp, Bridge
☐ Homeless Unknown Shelter ☐ Permanent Supportive Housing ☐ Single Occupancy Hotel (Other) ☐ At Risk for Homelessness
☐ At Risk for Homelessness (Child) ☐ At Risk for Homelessness (Veteran)

Are you a migrant / seasonal worker? ☐ Migrant ☐ Seasonal ☐ Neither

Veteran / Military Status ☐ Yes ☐ No, I am not a veteran (or served in the military)

Country of Origin ***(optional)*** _____

Would you like assistance during your appointment?

☐ Yes, support for Low Vision or Blindness.
☐ Yes, Hard of hearing.
☐ Yes, Mobility Assistance (please describe)_____
☐ Yes, other (please describe) _____

What pronouns do you use?

☐ She / Her / Hers ☐ He / Him / His ☐ They / Them / Theirs ☐ Ze / Hir / Hirs ☐ Ey / Em / Eirs ☐ Xe / Xem / Xyrs
☐ Ve / Vir / Virs ☐ Other ☐ Patient's Name ☐ Unknown ☐ Decline to Answer

Communication Preferences *(Circle One)*

How would you like to be contacted for Appointments?	Phone	Text	Email	Mail
Billing Issues	Phone	Text	Email	Mail
Healthcare Questions / Results	Phone	Text	Email	Mail
Messages from Your Provider	Phone	Text	Email	Mail
Other Communication	Phone	Text	Email	Mail

HIPAA Authorization

Elica Health Centers (Elica) wants to do all we can to protect your private health information. Telling Elica how you want to share information is called HIPAA Authorization. This helps us know what details, if any, you would like us to share with the people in your life. Elica providers do not / will not communicate with any patients regarding their treatment or care via email and/or text.

Tell us who you would like us to share or release information with

Name:	**Relationship:**

☐ We can tell this person any and all of your medical information.
OR
☐ We can give this person today's chart notes at the time of the visit.
☐ We can give this person all of your test results.

☐ **I do not want ANYTHING told or shared with ANYONE.**

This authorization to share your private health information will expire 1 year from the date of signing this form or upon *(describe terminating event)* _____.

Office Use Only

Effective Date:	**Updated By:**
Revoke Date:	**Updated By:**

Guarantor Information

☐ **Self**
☐ **For children - name of parent or legal guardian** _____ **Day of Birth** *(month/day/year)*_____
Address *(if different from patient's)* _____ **City** _____ **State** ___ **ZIP Code** _____

Relationship to Patient _____

Total number of people in your household (you and your dependents) _____

What is your household income before taxes $ _____ ☐ Hourly ☐ Monthly ☐ Annual ☐ Choose Not to Disclose

Note: I understand that if I choose not to disclose my household income and number of people in my household, I decline participation in Elica's financial assistance program (Sliding Fee). If my circumstances change, or if I change my mind, I know that I can ask a staff member for an application.

Insurance

Medicare Member ID Number _____ **Effective Date** _____

Medicaid Member ID Number _____ **Effective Date** _____

1. Give receptionist your insurance card and ID to scan in your chart
2. Turn in sliding fee application and proof of income for sliding scale (if self-pay)

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ **Print Name of Patient**

_____ **Relationship to Patient of Individual Signing Form** (for example: patient, parent, guardian)

_____ **Patient / Guardian Signature**

_____ **Date**

Consents & Acknowledgements

Treatment: I agree to receive treatment from Elica's providers and staff. I know that a medical record will be created about me. I can get a copy of my record by signing a Medical Records Authorization Form provided by the clinic.

Telehealth: I agree to receive care via telephone, telehealth, or the patient portal when medically necessary and clinically appropriate for exchanging medical information with my providers. Elica's providers can only legally treat patients located in California. Telehealth services cannot be provided to anyone currently outside of California for any reason.

Students / Residents: I understand that Elica is involved with the education of healthcare students. This means that students or residents may be present during visits for myself, my child, or the individual for whom I am a guardian. I understand that, under supervision of licensed healthcare providers, students or residents may assist with caring for myself, my child, or the individual for whom I am a guardian. I am aware that I can decline their participation in care at any time, and that this will not affect access to care.

Assignment of Benefits: I hereby assign all rights and benefits under my insurance policy to Elica allowing them to directly submit claims and receive payment from my insurance company on my behalf. I understand I am responsible for paying any charges my insurance doesn't cover, including the balance after discounts.

Photographs: I agree that Elica may take a photograph of myself, my child, or the individual for whom I am a guardian, for identification purposes in the health record. If I decline to have this photograph taken, I understand my legal photo ID may be used instead.

Patient Pharmacy Free Choice: I understand that I have the freedom to choose my pharmacy. Prescriptions will be sent to my pharmacy of choice. If eligible, I may be referred to a specific pharmacy for free or discounted medications. If I choose a different pharmacy, I may have to pay the full price.

Notice of Privacy Practices: I agree I was informed or have received a copy of Elica's Notice of Privacy Practices. I may access a copy of this at any time on Elica's website (www.elicahealth.org).

Health Information Exchange: Elica is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Elica, OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. I understand that health information may be shared by Elica with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement.

BY SIGNING BELOW, I CONFIRM I HAVE READ THE CONSENT SECTION, AND UNDERSTAND AND ACCEPT ITS TERMS.

_____
Print Name of Patient

_____
Relationship to Patient of Individual Signing Form
(for example: patient, parent, guardian)

_____
Patient / Guardian Signature

_____
Date

"Healing with Heart"
Elica Health Centers

PEDIATRIC HEALTH HISTORY AGES 0-12

Patient Name	**MRN:**	**Today's Date** (month/day/year)
Date of Birth (month/day/year)		

ALLERGIES TO ANY MEDICATIONS, FOOD OR OTHER SUBSTANCES?

Allergic to:	**Reaction:**	**Severity of Reaction:**
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High
	☐Anaphylaxis ☐ Hives ☐Rash ☐ Swelling ☐Nausea/ vomiting ☐Other:_____	☐Low ☐Medium ☐High

MEDICAL HISTORY (Check all diseases and medical conditions that apply)

☐No Past Medical History

☐Abuse as Adult (victim)	☐Asthma	☐Depression	☐Heart Failure	☐Liver disease	☐Sickle cell anemia
☐Abuse as a child (victim)	☐Blood Transfusion	☐Diabetes mellitus	☐Heart murmur	☐Meningitis	☐Stomach ulcers
☐Allergies	☐Cancer	☐Emphysema/COPD	☐HIV/AIDS	☐Myocardial infarction	☐Stroke
☐Anemia	☐Cataracts	☐GERD	☐Hyperlipidemia	☐Nerve/Muscle disease	☐Substance abuse
☐Anxiety	☐Clotting disorder	☐Glaucoma	☐Hypertension	☐Osteoporosis	☐TB disease
☐Arthritis/Join disorder	☐COPD	☐Heart disease	☐Kidney disease	☐Seizures	☐Thyroid disease

☐Other, please explain:

SURGICAL HISTORY

☐No Past Surgical History

☐Appendectomy	☐Cosmetic surgery	☐Small intestine surgery
☐Brain surgery	☐Eye surgery	☐Spine surgery
☐Breast surgery	☐Fracture surgery	☐Third Molar Extraction

☐CABG	☐Hernia repair	☐Tonsillectomy
☐Cholecystectomy	☐Joint replacement	☐Valve replacement
☐Colon surgery	☐Prostate surgery	☐Vasectomy
☐Other, please explain:		

FAMILY HISTORY (Check all diseases and conditions that apply)

		No Known Problems	Alcohol/Drug Use	Allergies	Alzheimer's Disease	Anemia	Autoimmune Disease	Breast Cancer	Colon Cancer	Cancer	Depression	Diabetes	Heart Attack	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Lung Disease	Stroke	Sudden Death	Suicide	Thyroid Disease	Vision Problems	Other
Relationship	**Name**																							
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								
Maternal Aunt																								
Maternal Uncle																								
Paternal Aunt																								
Paternal Uncle																								
Maternal Grandmother																								
Maternal Grandfather																								
Paternal Grandmother																								
Paternal Grandfather																								
Other																								

LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:

Disease or medical problem:	Family member:

Complete for children ages 8-12: SCARED, BRIEF (Child answers)

I get really frightened for no reason at all:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am afraid to be alone in the house:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
People tell me that I worry too much:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am scared to go to school:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True
I am shy:	☐Not true or Hardly ever true	☐ Somewhat True or Sometimes True	☐ Very True or Often True

TB RISK ASSESSMENT

Recent close or prolonged contact with someone with infectious TB disease	☐Yes	☐No
Born in or recent traveler to high prevalence area	☐Yes	☐No
Chest radiographs with fibrotic changes suggesting inactive or past TB	☐Yes	☐No
HIV infection	☐Yes	☐No
Organ transplant recipient	☐Yes	☐No
Immunosuppression secondary to use of prednisone (equivalent of > or = to 15mg/day for >or = 1 month) or other immunosuppressive medication such as TNF -α antagonist	☐Yes	☐No
Injection drug user	☐Yes	☐No
Resident or employee of high-risk congregate setting (e.g.,prison, long-term care facility, hospital, homeless shelter)	☐Yes	☐No
Medical condition associated with risk of progressing to TB disease if infected (e.g. diabetes mellitus, silicosis, cancer if head or neck, Hodgkin's Disease, leukemia, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population))	☐Yes	☐No

Signs/Symptoms of TB ☐ Persistent Cough ☐Persistent fever ☐ Unexplained weight loss ☐Loss of appetite ☐ Persistent sweats
☐Chronic fatigue ☐ Chills ☐Coughing up blood ☐ Shortness of breath ☐Chest pain ☐ None

SOCIAL HISTORY (PRAPARE): For Parent or Caregiver

How hard is it for you to pay for the very basics like food, housing, heating, medical care, and medications?
☐Not hard at all ☐ Somewhat hard ☐ Very hard ☐Decline

What is your living situation today?
☐I have a steady place to live
☐I have a place to live today, but I am worried about losing it in the future
☐I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the streets, on the beach, in the car.)
☐Decline

In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
☐Yes, it has kept me from medical appointments or getting medications
☐Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
☐No
☐Declined

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
☐Less than once a week ☐ 1-2 times a week ☐ 3-5 times a week ☐ 5 or more times a week ☐Decline

How often do you experience stress?
☐Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐Decline

Are you currently employed? ☐Yes ☐ No ☐ Decline

Would you like assistance with any of the above items? ☐Yes ☐ No

Type of assistance: ☐ Written information ☐ Contact me

What do you want help with?

☐Health Literacy ☐ Education ☐ Financial Strain ☐Transportation ☐ Employment ☐ Utilities
☐Physical Activities ☐ Stress ☐ Isolation ☐Housing ☐ Food ☐Relationship

MEDICATION
(List all current medications: prescribed, over-the-counter drugs, vitamins & inhalers and the dosage)

Medication	Dosage	Frequency

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS OR SPECIALISTS?
(LIST ALL BELOW)
Medical Assistant: Complete a medical record release form for all medical providers listed below and add to Care Team in Epic

Physician/Practice Name	Specialty	Address	Phone

DENTAL HISTORY

1. Have you had problems with prior dental treatment?	☐Yes	☐No
2. Date of last dental exam:		
3. Have you ever been premedicated for dental treatment? If yes, why?	☐Yes	☐No
4. Have you taken bisphosphonates?	☐Yes	☐No

ALLERGIES AND REACTIONS		
Are you allergic to Latex? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to local anesthetic? If yes, please explain the reaction.	☐Yes	☐No
Are you allergic to Nitrous oxide? If yes, please explain the reaction.	☐Yes	☐No

Patient / Legal Guardian Name

Relationship to patient of Individual Signing Form
(example: patient, parent, guardian)

Patient / Legal Guardian Signature

Date

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Name	**MRN:**	**Today's Date** (month/day/year)

You must provide proof of income for every adult household member. Examples: a copy of the most recent tax return, your two most current pay stubs, most recent W2's, etc. You must submit documentation within 10 days of your application date.

Name	Relationship	Age	Income Amount	# Hours Worked (per week)	Pay Frequency
	self				❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income
					❒ Hourly Wage ❒ Annual Income

Do you have any other sources of income not listed above? If yes, please provide:
(unemployment, disability/workers comp, social security, pensions, public assistance, etc…) $_____
(monthly)

Total Number of People in Your Household:
(include yourself/spouse, children, and any taxable dependent relatives living with you) _____

I hereby request Elica Health Centers to determine my eligibility for the sliding fee program based on the information I have submitted. I also understand that if the information which I submit is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm that the information provided above is true and correct to the best of my knowledge. I understand that it is my responsibility to inform Elica Health Centers of all changes to my insurance information. Should I fail to do so, payment in full for all services will be my responsibility.

Signature: _____ Date: _____

VERIFICATION AND DETERMINATION (Office Use Only)

1. Household Income verified: ❒ Yes ❒ No (Patient will provide) ❒ No (Self-Declaration Form)
2. If "No," Date documents due: _____. Date documents provided: _____.
3. SFDP Level: ❒ Slide A (< 100%) ❒ Slide B (101 - 124%) ❒ Slide C (125 - 149%)
   ❒ Slide D (150 - 174%) ❒ Slide E (175 - 200%) ❒ Full Fee (> 200%)
4. SFDP Expires: _____

Verified by: _____ Date: _____

Social Care Referral: ❒ Yes ❒ No Date: _____

Elica Health Centers

SLIDING FEE PROGRAM SELF-DECLARATION FORM

Patient Name	**MRN:**	**Today's Date** (month/day/year)

If you do not have financial support or documentation of your income, you can let us know by filling out this form.

To self-attest, please select 1 of the following options and sign at the bottom.

I certify that I have no other way to document my income. This is because:

- ☐ I am paid in cash. I do not get paychecks/pay stubs.
- ☐ I am unable to provide any proof of income because neither I nor any other member of my household has any source of income.

I certify that I have no other way to document my income. I affirm that the above information is true and correct to the best of my knowledge. I understand that if the information I give is determined to be false, I will be denied financial assistance, and I will be responsible for and expected to pay for the services provided.

_____ _____

Patient/Legal Guardian Name (Print)

Relationship to patient of Individual Signing Form
(For example, patient, parent, guardian)

_____ _____

Patient/Legal Guardian Signature

Date

VERIFICATION AND DETERMINATION (Office Use Only)

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used my best efforts to obtain other possible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature: _____ Date: _____