"Healing with Heart" Elica Health Centers

PATIENT REGISTRATION

Last Name	First Name	Middle Name	
Social Security Number	Birth Date	Birth Sex ☐ Male ☐ Female	Legal Sex ☐ Male ☐ Female

Preferred Name

Preferred Pronouns
☐ He, Him, His ☐ They, Them, Theirs ☐ She, Her, Hers

Gender Identity
☐ Female ☐ Male to Female ☐ Choose not to disclose
☐ Male ☐ Female to Male ☐ Additional Gender or Other please specify:
☐ Gender Non-Conforming

Sexual Orientation
☐ Bisexual ☐ Don't Know
☐ Straight or Heterosexual ☐ Choose not to disclose
☐ Lesbian, Gay or Homosexual

Home Address			Mailing Address (if different)		
City	State	Zip Code	City	State	Zip Code

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

Visit Type Preference
☐ Video Visits ☐ Doesn't Matter
☐ Office Visits ☐ Always Office Visits

Preferred Language

Will you need interpretation services if your provider does not speak your preferred language? ☐ Yes ☐ No

Contact Information
Preferred Phone ( )
☐ Home
☐ Cell
☐ Work

Email Address

Secondary/Other Phone
( )

☐ Home ☐ Cell ☐ Work ☐ Other:
☐ This number belongs to a friend/relative. Please specify name & relationship.
Name_____ Relationship_____

Preferred Contact
☐ Home Phone ☐ Email/Patient Portal
☐ Work Phone ☐ Mail
☐ Cell Phone

Would you like to communicate with your provider via the Patient Portal? ☐ Yes ☐ No

Patient care summary delivery preference:
☐ Portal ☐ Paper

Preferred Pharmacy
☐ CVS ☐ Innova ☐ Raley's ☐ Rite Aid ☐ Safeway
☐ Walgreens ☐ Walmart ☐ Target ☐ Other: _____

Pharmacy Location
(address or cross streets)

Sharing your demographic information helps Elica continue to seek funding for services.

Total number of people in your household (you and your dependents): _____ ☐ Choose not to disclose

Total number of children under 18 in your household: _____ ☐ Choose not to disclose

Which of the following best describes your household?
☐ Individual ☐ Single Female Head of Household ☐ Single Male Head of Household
☐ Two-parent household ☐ Choose not to disclose

What is your household income before taxes?
$_____
☐ Year ☐ Every 2 weeks ☐ Every week
☐ Month ☐ Twice a month ☐ Choose not to disclose

In the past calendar year (since January 1) were you ever homeless or in a temporary shelter?
☐ Yes, please choose one (1) below ☐ Choose not to disclose
☐ No

☐ Homeless Shelter ☐ Street ☐ Transitional
☐ Doubling Up ☐ Permanent Supportive Housing ☐ Other:_____

At any point in the past 2 years, has agricultural work been your family's main source of income?
☐ No ☐ Choose not to disclose
☐ Yes, migrant farm ☐ Yes, seasonal farm

What is your race or biological family background? (Check all that apply)
☐ American Indian/Native Alaskan ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Black/African American ☐ Asian ☐ Choose not to disclose

Are you Hispanic or Latino(a)? ☐ Yes ☐ No ☐ Choose not to disclose

Are you a Veteran? ☐ Yes ☐ No ☐ Choose not to disclose

Emergency Contact

Last Name	First Name
Phone Number	**Relationship to Patient**

If patient is under 18 years old , list ALL legal Parents/Guardians ☐ Patient is a foster child

Legal Parent/Guardian #1 (First Name, Last Name)			Legal Parent/Guardian #2 (First Name, Last Name)		
Relationship		**Custody** ☐ Sole Legal ☐ Joint Legal	**Relationship**		**Custody** ☐ Sole Legal ☐ Joint Legal
Social Security Number	**Birthdate**	**Guarantor?** ☐ Yes ☐ No	**Social Security Number**	**Birthdate**	**Guarantor?** ☐ Yes ☐ No
Street Address ☐ **Same as patient's address**			**Street Address** ☐ **Same as patient's address**		
City	**State**	**Zip**	**City**	**State**	**Zip**
Phone	**Email**		**Phone**	**Email**	

How did you hear about Elica Health Centers?

☐ Advertising	☐ Friend/Family	☐ Media	☐ Primary Care Provider
☐ Specialist Physician	☐ Event	☐ Word of Mouth	☐ Patient in the Practice
☐ Insurance Company	☐ Existing Patient	☐ Church	☐ Elica Employee
☐ Hospital	☐ School District	☐ Elica Board Member	☐ Other:

Insurance & Payment

Do you have Medical Insurance?
☐ Yes (provide copy of insurance card)
☐ No

Do you have Dental Insurance?
☐ Yes (provide copy of insurance card)
☐ No

Consents & Acknowledgement

Treatment: I consent to the treatment that will be provided by Elica Health Centers' (EHC) providers, as well as their assistants and other EHC staff members. I understand that a medical record will be prepared and maintained about me by the clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the clinic for that purpose.

Students/Residents: I understand that EHC participates in the education of students in healthcare. I can decline their participation in my care at anytime.

Telehealth: I consent to receiving care via telephone, telehealth or patient portal when medically necessary and clinically appropriate to exchange medical information between me and the provider, or between one provider and another provider.

Assignment of Benefits: I authorize payment directly to EHC of benefits otherwise payable to me but not to exceed EHC's regular charges for this service. I understand that I am financially responsible to EHC for any charges not covered by my insurance, including the balance of my charges after any discount has been applied.

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of EHC's Collections Policy. Elica Health Centers is not a free clinic and failure to fulfill your financial responsibility to us or agree to a payment schedule may result in your financial discharge from our services. In accordance with EHC's Collection Policy, EHC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices.

Validity of Consent: I understand that this consent will be valid as long as I am a patient or legal guardian of a patient of Elica Health Centers. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the clinic. The withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent.

BY SIGNING BELOW, I CONFIRM THAT THE INFORMATION PROVIDED ON THE PATIENT REGISTRATION FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT 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
Witness (Clinic Staff Member)	Date

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PEDIATRIC HEALTH HISTORY

(Ages 0 to 17 years)

TOBACCO USE

Have you ever smoked or used cigarettes, e-cigarettes, vape pens, hookahs or other tobacco products?	☐ Yes ☐ No
Any smokers in the house?	☐ Yes ☐ No

COMPLETE THE SECTION BELOW IF YOU HAVE EVER USED TOBACCO

Tobacco smoking status? (choose one) ☐ Former user ☐ Current every day ☐ Current someday	**Smokeless tobacco status? (choose one)** ☐ Former ☐ Current snuff user ☐ Current chew user ☐ Current moist powdered user
Approximately how much do you smoke? ☐ 1ppw ☐ 2ppw ☐ ¼ ppD ☐ ½ ppD ☐ 1ppD ☐ 1 ½ ppD ☐ 2ppD ☐ 3+ ppD	**Chewing tobacco use?** ☐ 1/day ☐ 2-4/day ☐ 5+/day **E-cigarette/vape status?** ☐ Former user ☐ Current user
Has smoke since age?	Tobacco-years of use?

ALCOHOL INTAKE

Do you drink alcohol?	☐ Yes ☐ No
How many drinks per week?	
How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)?	

DRUG USE

Do you currently use marijuana or other recreational drugs?	☐ Yes ☐ No
Do you have a history of marijuana or other drug use?	☐ Yes ☐ No
Have you ever used needle to inject drugs?	☐ Yes ☐ No

SOCIAL HISTORY

City, State, Country of Birth:					
Where do you live? (choose one) ☐ House ☐ Apartment ☐ Trailer ☐ Condo ☐ Other:					Is the house you live in built before 1978? ☐ Yes ☐ No
Parents' Marital Status (check one): ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed					
Do you have a caregiver? ☐ Yes ☐ No If yes, state name & relation:					Exposed to animals/pets? ☐ Yes ☐ No If yes, what kind?
Occupation:					
Education: ☐ Less than 8th grade	☐ 8th grade ☐ 12th grade	☐ 9th grade ☐ 2-year college	☐ 10th grade ☐ 4-year college	☐ 11th grade ☐ Post graduate	
Number of living children: 0 1 2 3 4 5 6 7 8 9+					Currently pregnant? ☐ Yes ☐ No
Caffeine Intake? ☐ None ☐ Occasional ☐ Moderate ☐ Heavy			How many cups per day?		
Concerns about meeting basic needs (food, housing, heat, etc.)?					☐ Yes ☐ No
In the past year, have you been afraid of your partner or ex-partner?					☐ Yes ☐ No ☐ Unsure ☐ Have not had a partner in the past year ☐ Choose not to answer
Do you feel physically and emotionally safe where you currently live					☐ Yes ☐ No ☐ Unsure ☐ Choose not to answer
In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?					☐ Yes ☐ No ☐ Choose not to answer
Is blood transfusion acceptable in an emergency?					☐ Yes ☐ No
Do you have an Advance Directive?					☐ Yes ☐ No
Do you have any social needs that need to be addressed? ☐ Yes ☐ No If yes, please describe below:					

PARENT/GUARDIAN SIGNATURE **DATE**