"Healing with Heart"
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		

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

Gender Identity
☐ Female ☐ Male
☐ Transgender Male/Trans Man/FTM ☐ Transgender Female/Trans Woman/MTF
☐ Non-Binary/Genderqueer ☐ 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?
☐ Not Hispanic, Latino/a or Spanish Origin ☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban
☐ Other Hispanic, Latino/a or Spanish Origin ☐ Unreported / Choose Not to Disclose Ethnicity

What is your race or biological family background? (Check all that apply)
☐ American Indian ☐ Alaska Native ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro
☐ Samoan ☐ White ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Other Race
☐ Unknown ☐ Unreported / Choose Not to Disclose

Emergency Contact

Name	
Phone Number	**Relationship to Patient**

Patient Contacts

Spouse, Mother, Father, Caregiver or Guardian info:

Name_____ **DOB** _____ **Relationship to Patient** _____
Address _____ **City** _____**State** _____ **ZIP Code** _____
Phone Number _____ **Release Medical Information** ☐ Yes ☐ No

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

Employment

Employment Status ☐ Full time ☐ Part time ☐ Unemployed

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**

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) _____

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

Additional Demographics

Country of Origin _____

ID/Driver License _____ **State** _____ **Expiration Date** _____

Insurance Guarantor

☐ 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 $ _____ ☐ Monthly ☐ Yearly ☐ Choose Not to Disclose

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

How do you want us to contact you

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

Insurance

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

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

1. Give receptionist your insurance card and CA ID to copy for your chart
2. Turn in Federal poverty level application and proof of income for sliding scale (if self-pay)
3. Receptionist will scan your documents into your chart

Insurance Name (Anthem, Aetna, HealthNet, etc.) _____

Insurance Member ID _____

Subscriber/Member Name on Card _____

Subscriber DOB _____

Effective Date _____

Insurance Group Info:

☐ Nivano
☐ River City Medical Group
☐ Partnership Health
☐ Hill Physicians
☐ Molina
☐ Other _____
(Name of group i.e; Wellspace, One Community, CHCN, Kaiser, etc.)

I declare under penalty of perjury that the above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE **DATE**

Consents & Acknowledgements

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. **Initials: _____**

Students/Residents: I understand that EHC participates in the education of students in healthcare. I can decline their participation in my care at any time. **Initials: _____**

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. **Initials: _____**

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. **Initials: _____**

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. **Initials: _____**

Patient Pharmacy Free Choice (As required by U.S. Department of Health and Human Services, Resources and Services Administration (HRSA) and the State of California) I hereby acknowledge that I am free to choose a pharmacy. Any fax or electronic transmission of my prescriptions shall be to the pharmacy or dispensary I select. If I am eligible for medications through a free or discount pharmacy program, I will be directed to a specific dispensary or pharmacy. Elica has free or discounted medications at certain contracted pharmacies. If I chose not to use a contracted pharmacy, I may have that prescription filled at another pharmacy, at a non-discounted price. **Initials: _____**

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

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. **Initials: _____**

Photographs: I consent for photographs to be made of me or my child (or person for whom I am legal guardian). I understand the information will only be used for my health record for identification purposes. **Initials: _____**

Elica Health Centers 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 health Centers, 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. Your health information may be shared by Elica Health Centers with other OCHIN participants, when necessary for health care operation purposes of the organization is health care arrangement. **Initials: _____**

Open Payments: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. **Initials: _____**

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**

"Healing with Heart" Elica Health Centers

PATIENT PRIVACY

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

Patient Information			
Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:**
Legal Parent/Guardian/ Conservator #1 (if applicable):		**Legal Parent/Guardian/ Conservator #2 (if applicable):**	

Message Preferences: Tell us the type of messages you prefer and what we can share. (Messaging and data rates may apply.)	Phone	Text	Email/Portal
All of the below	☐	☐	☐
Health Notifications (such as lab or test results)	☐	☐	☐
Appointment Reminders	☐	☐	☐
Announcements (such as new programs or community information)	☐	☐	☐
Billing Notifications	☐	☐	☐

Who: Tell us who you would like us to share, or release, information with. Each box is for a different person.

Person #1		**Person #2**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ 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.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

Person #3		**Person #4**	
Name:		**Name:**	
Relationship:		**Relationship:**	
☐ We can tell this person any and all of your medical information.		☐ We can tell this person any and all of your medical information.	
OR		**OR**	
☐ We can give this person today's chart notes at the time of the visit.		☐ 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.		☐ We can give this person all of your test results.	
Office Use Only		**Office Use Only**	
Effective Date:	Updated by:	Effective Date:	Updated by:
Revoke Date:	Updated by:	Revoke Date:	Updated by:

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

By signing this form, I acknowledge receipt of the Clinic's **Notice of Privacy Practices** and authorize Elica Health Centers to share my health information to the listed individuals as indicated above.

_____	_____
Print Name of Patient	Relationship to Patient of Individual Signing Form (for example, patient, parent, guardian, caregiver)
_____	_____
Patient/Guardian Signature	Date
_____	_____
Witness (Clinic Staff Member)	Date

"Healing with Heart" Elica Health Centers

ADULT HEALTH HISTORY

Patient Name:	Date of Birth:

ARE YOU CURRENTLY UNDER THE CARE OF ANY OTHER PHYSICIANS OR SPECIALISTS? (LIST ALL BELOW)

Physician/Practice Name	Specialty	Address	Phone

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Latex	☐ Penicillin	☐ Sulfa Drugs	☐ None

List All Known Allergies & Reactions:

MEDICATION
(LIST ALL CURRENT MEDICATIONS: PRESCRIBED, OVER-THE-COUNTER DRUGS, VITAMINS & INHALERS AND THE DOSAGE)

Medication	Dosage	Frequency

CHECK ALL VACCINATIONS THAT YOU HAVE RECEIVED

☐ Tetanus & diphtheria (Td)	Date received (approx.) _____/_____
☐ Tetanus, diphtheria & acellular pertussis (Tdap)	Date received (approx.) _____/_____
☐ Pneumococcal	Date received (approx.) _____/_____
☐ Varicella (VAR)	Date received (approx.) _____/_____
☐ Varicella Zoster Virus (VZV)	Date received (approx.) _____/_____
☐ Zoster Vaccine Live (ZVL)	Date received (approx.) _____/_____

Can you provide us with your immunization records? ☐ YES ☐ NO

TB RISK ASSESSMENT

Had close contact with someone with infectious TB disease or someone who has been to jail/prison?	☐ Yes ☐ No
Immunosuppression, current or planned (HIV infection, organ transplant recipient, etc.)	☐ Yes ☐ No
Were you born, travel or lived in a country with an elevated TB rate for at least 1 month? (Outside of the US, Canada, Australia, New Zealand or a country in Western or Northern Europe)	☐ Yes ☐ No

SURGICAL HISTORY: LIST ANY PAST SURGERIES BELOW.

No Past Surgeries

Name/Type of Surgery	Date of Surgery

"Healing with Heart" Elica Health Centers

ADULT HEALTH HISTORY

FAMILY HISTORY: CHECK ALL DISEASES AND CONDITIONS THAT APPLY					
Disease or Problem	**X**	**Family member(s)**	**Disease or Problem**	**X**	**Family member(s)**
Alcohol abuse			Hypocholesterolemia		
Alzheimer's disease			Hypertensive disorder		
Anemia			Immunodeficiency disorder		
Anxiety disorder			Kidney disease		
Asthma			Liver problems		
ADHD			Mental disorder		
Bipolar disorder			Heart Attack (MI)		
Depressive disorder			Obesity		
Diabetes mellitus			Panic Disorder		
Disorder of lung			Schizophrenia		
Disorder of nervous system			Seizure disorder		
Disorder of thyroid gland			Substance abuse		
Headache			Tuberculosis		
Heart disease			Ulcer		
History of attempted suicide			Family history unknown		

LIST ANY OTHER FAMILY MEDICAL HISTORY BELOW:	
Disease or Medical Problem:	**Family Member:**

MEDICAL HISTORY: CHECK ALL DISEASES AND CONDITIONS THAT APPLY					
No Past Medical History					
Disease or Problem	**X**	**Disease or Problem**	**X**	**Disease or Problem**	**X**
ADD/ADHD		Dementia		Muscle, Joint, or Bone Problems	
AIDS/HIV		Depression		Nervous System Disorder	
Abdominal Pain		Diabetes		Organ Transplant	
Acid Reflux (GERD)		Dialysis		Osteoporosis	
Anemia		Ear or Hearing Problems		Polyps	
Anxiety Disorder		GI Problems		Psychiatric/ Mental Health Condition	
Arthritis		Gout		Seizures/Epilepsy	
Asthma		Headaches		Skin Problems	
Autoimmune Disease		Heart Disease		Stroke	
Back Pain		Hernia		Thyroid Problems	
Bladder or Kidney Problems		High Blood Pressure		Depression/Postpartum Depression	
Bleeding Disorder		High Cholesterol		Vision or eye problems (blind)	
Blood Clot		Incontinence		Urinary Problems	
Blood Disease		Leg or Foot Ulcers		Other:	
Cancer		Liver Disease			
Congestive Heart Failure (CHF)		Lung Disease			

"Healing with Heart" Elica Health Centers

ADULT HEALTH HISTORY

GYNECOLOGICAL HISTORY		DENTAL HISTORY	
Abnormal Pap?	☐ Yes ☐ No	Were you referred to Dentistry?	☐ Yes ☐ No
HPV Vaccine?	☐ Yes ☐ No	Are you currently experiencing any pain?	☐ Yes ☐ No
STIs/STDs?	☐ Yes ☐ No	Have you ever had a serious/difficult problem associated with any previous dental work?	☐ Yes ☐ No
Age at menarche (first menstruation):		Are you or have you taken bisphosphonates (Fosamax)?	☐ Yes ☐ No
Current Birth Control Method:			
Date of Last Menstrual Period:		Are you or have you taken Fen-Phen?	☐ Yes ☐ No
Date of Last Mammogram:			
Date of Last Pap Smear:		Have you ever been pre-medicated for dental treatment?	☐ Yes ☐ No
If Post-Menopausal, Age at Menopause:			

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

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 ☐ 9th grade ☐ 10th grade ☐ 11th grade
☐ 12th grade ☐ 2-year college ☐ 4-year college ☐ 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:

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?

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ADULT HEALTH HISTORY

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

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

PATIENT SIGNATURE **DATE**