The Community Health Clinic

Patient Demographics

Patient Name: _____ Previously Used Name: _____

Social Security #: _____ Gender: _____ Date of Birth: _____

Is the patient pregnant? ☐ Yes; Due Date: _____ ☐ No ☐ Not Applicable

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline Race: _____ Religion: _____

Address: _____ Apt/Lot: _____ City: _____ State/Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Email: _____ ☐ None

Preferred Language? _____ Interpreter Needed: ☐ Yes ☐ No

Employment: ☐ Full time ☐ Part time ☐ Unemployed Employer: _____

Married? ☐ Yes ☐ No Spouse's Name: _____

Father's Name: _____ Date of Birth: _____

Address: _____ ☐ Same as Above

Mother's Name: _____ Maiden Name: _____ Date of Birth: _____

Address: _____ ☐ Same as Above

Emergency Contacts

Name: _____ Relationship: _____ Phone #: (_____)_____

Name: _____ Relationship: _____ Phone #: (_____)_____

Primary Care Physician

Name: _____ City: _____ Phone #: _____

Preferred hospital: _____ City/State: _____

Preferred pharmacy: _____ City/State: _____

Responsible For Payment

Patient Guarantor: _____ Relationship to Patient: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State/Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Address: _____

Please check any of the following resources you would like more information about:

☐ Children's Special Healthcare Services (CSHCS) ☐ Indiana Medicaid ☐ First Steps

☐ Medicare/State Health Insurance Assistance Program (SHIP) ☐ Womens, Infant, and Children's Program (WIC)

FOR OFFICE USE ONLY

Payment Information

1. Insurance

☐ Medicaid ☐ Medicare ☐ CSHCS ☐ NORD

2. Plain Church Group

District #: _____

3. Self Pay

☐ Insurance Name: _____

☐ Uninsured

The Community Health Clinic

CONSENT TO TREAT

I, _____, do hereby voluntarily consent to any medical care determined by the Community Health Clinic medical team to be necessary for my welfare. This includes diagnostic and treatment procedures judged necessary by the medical team. I acknowledge no guarantees have been made to me as to the result of such treatment.

I understand that, as a part of standard medical practice, de-identified data (information that can't be used to find out who I am) from my medical record may be used or shared for research purposes.

By signing below, I acknowledge that I have read and understand the above consent to treatment. If I do not understand, I will ask for it to be explained in terms I fully understand.

Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____

The State of Indiana defines legal guardianship as follows: A **legal guardian** has the **legal** authority and duty to care for another person, called a "ward." **Legal guardians** are usually found in one of three situations: **guardianship** of an elderly person incapacitated by infirmity or old age; **guardianship** of a developmentally disabled adult; and the **guardianship** of a minor **child**. If you are signing as **legal guardian**, proof of guardianship is required.

MEDICAL PAYMENT AND FINANCIAL RESPONSIBILITY

I hereby assign, to the physician(s), all insurance payments for medical services rendered to me. I understand that I am financially responsible to the Community Health Clinic for the health services rendered to the above listed patient. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs and reasonable legal fees.

Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____

PATIENT EDUCATION INFORMATION

We are required to provide information regarding health related issues and the possible affects they may have on children and pregnant mothers. Your signature below is acknowledgement that you have received patient education information.

Signature: _____ Date: _____

Print Name: _____

The Community Health Clinic

CONSENT TO TREAT MINOR

I, _____, parent or legal guardian of _____, do hereby voluntarily consent to any medical care determined by the Community Health Clinic medical team to be necessary for the welfare of my child. This includes diagnostic and treatment procedures judged necessary by the medical team. I acknowledge no guarantees have been made to me as to the result of such treatment.

I understand that, as a part of standard medical practice, de-identified data (information that can't be used to find out who my child is) from my child's medical record may be used or shared for research purposes.

By signing below, I acknowledge that I have read and understand the above consent to treatment. If I do not understand, I will ask for it to be explained in terms I fully understand.

Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____

The State of Indiana defines legal guardianship as follows: A **legal guardian** has the **legal** authority and duty to care for another person, called a "ward." **Legal guardians** are usually found in one of three situations: **guardianship** of an elderly person incapacitated by infirmity or old age; **guardianship** of a developmentally disabled adult; and the **guardianship** of a minor **child**. If you are signing as **legal guardian**, proof of guardianship is required.

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Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____

PATIENT EDUCATION INFORMATION

We are required to provide information regarding health related issues and the possible affects they may have on children and pregnant mothers. Your signature below is acknowledgement that you have received patient education information.

Signature: _____ Date: _____

Print Name: _____

The Community Health Clinic

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect for protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or on the phone (260) 593-0108.

Your signature below is acknowledgement that you have received this Notice of Privacy Practices.

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Print Name: _____

HIPAA FAMILY MEMBER/FRIEND INFORMATION

According to HIPAA privacy standards, the Community Health Clinic, may share protected information with family members or friends who are involved in the patient's care as long as the patient or personal representative has an opportunity to object. If the patient is unable to object, for whatever reason, we will use our professional judgment.

To enable us to share this information with specific family members or friends according to your wishes, please list specific names and relationships below of those individuals with whom your protected health information can be shared. You must sign and date this section.

The following family members or friends can receive my protected health information as necessary for my care or payment for that care:

Except in very special circumstances, State and Federal laws give parents equal right to protected health information for minor children. If patient is a minor you do not need to list parents below.

You may choose to change or revoke this consent at any time.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

MRN: _____

The Community Health Clinic

Patient's Name: _____

Date of Birth: _____

Please provide a list of physicians involved in patient's care

Physician's Name _____

Specialty _____

Address _____

Phone Number _____ Fax Number _____

Physician's Name _____

Specialty _____

Address _____

Phone Number _____ Fax Number _____

Physician's Name _____

Specialty _____

Address _____

Phone Number _____ Fax Number _____

Physician's Name _____

Specialty _____

Address _____

Phone Number _____ Fax Number _____

Physician's Name _____

Specialty _____

Address _____

Phone Number _____ Fax Number _____

The Community Health Clinic

Patient's Name _____

Date of Birth _____

MEDICATIONS AND ALLERGIES

Please complete and bring with you to your appointment. Please include prescription medications, over-the-counter medications, and vitamins.

NAME OF MEDICATION	STRENGTH/DOSAGE	FREQUENCY

ALLERGY	REACTION

The Community Health Clinic

PATIENT AUTHORIZATION FOR PRACTICE TO OBTAIN PROTECTED HEALTH INFORMATION

I hereby request The Community Health Clinic and its medical staff and employees to obtain the following identified information:

Medical Records, to give testimony by deposition or otherwise, with regard to:

Patient's Name	**Date of Birth**
Address	City State Zip Code

This information is being requested for said patient's continuing care with

Dr. Zineb Ammous, M.D. at the medical facility listed below:

The Community Health Clinic
315 Lehman Avenue, Suite C
Topeka, IN 46571
Phone: 260-593-0108
Fax: 260-593-0116

IN ORDER TO OBTAIN (Check ONE of the following)

□ **Complete Medical Record: any and all diagnostic testing (inclusive of genetic), imaging/radiology and notes there from, doctors' dictations and any other information helpful in treating above patient**

□ **Other**_____

_____

•This Authorization will be considered valid for the period of time above stated person is a patient with the Community Health Clinic.

•I understand that The Community Health Clinic may not require me to sign this Authorization as a condition to providing health care treatment to me.

•I understand that this Authorization is subject to revocation at any time, except to the extent that action has been taken in reliance on this Authorization. In order to revoke this Authorization, I must deliver a revocation, in writing, to The Community Health Clinic and that after such revocation is delivered to The Community Health Clinic, no further information will be furnished pursuant to this Authorization

•When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient | Date

The Community Health Clinic

CHC Family Health History Questionnaire

It is important for us to have an accurate and complete picture of the health and special needs of your family. Please answer the questions below to the best of your knowledge. Prior to your visit, we will review this information as it pertains to you/your family member's visit.

PATIENT NAME: _____

1. Date of birth (MM/DD/YYYY): _____
2. Gender: ☐ Male ☐ Female
3. Is the patient adopted? ☐ Yes ☐ No
4. Race: _____
5. Ethnicity (where your relatives are originally from, example: Europe – Germany):

   _____
6. Do you have an Amish, Mennonite, or Ashkenazi Jewish background?
   - ☐ No
   - ☐ Yes (please specify):
     - ☐ Amish: _____
     - ☐ Mennonite: _____
     - ☐ Ashkenazi Jewish: _____
     - ☐ Other: _____
7. During your visit with the CHC what are your goals:
   a. Diagnosis: Help find a diagnosis for yourself/your child/family member.
   b. Genetic Counseling: Understand a genetic condition that you/your child/family member has been diagnosed with.
   c. Second Opinion
   d. Other: _____
8. Has the patient ever seen a geneticist before:

   ☐ No ☐ Yes (Name of Doctor): _____
9. Has the patient ever had genetic testing done before:

   ☐ No ☐ Yes (Ordering Doctor/Where/What tests): _____

   _____

   _____

DATE: _____ Initial _____ PATHIST

10. Please describe the concerns you have for you/your child/family member and their symptoms? _____

_____

_____

_____

11. Does the patient have any of the following? If yes, please describe.

Birth defects	☐ No	☐ Yes:
Trouble reaching developmental milestones (sit, crawl, walk, talk, etc.)	☐ No	☐ Yes:
Loss of developmental milestones previous achieved	☐ No	☐ Yes:
Slow learning, intellectual disability	☐ No	☐ Yes:
Difficulty feeding/digestive issues	☐ No	☐ Yes:
Growth or height issues	☐ No	☐ Yes:
Seizures or staring spells	☐ No	☐ Yes:
Hearing loss, deafness, or other ear issues	☐ No	☐ Yes:
Visual impairment, blindness, or other eye issues	☐ No	☐ Yes:
Cancer	☐ No	☐ Yes:
Hair or skin problems or unusual lumps/growths	☐ No	☐ Yes:
Heart problems (birth defect, cardiomyopathy, heart beat irregularity)	☐ No	☐ Yes:
High or low muscle tone (tight or weak muscles)	☐ No	☐ Yes:
Recurring/frequent infections	☐ No	☐ Yes:
Autism or autistic-like features or abnormal behaviors	☐ No	☐ Yes:
Lung or breathing problems	☐ No	☐ Yes:
Movement problems	☐ No	☐ Yes:
Other medical problems	☐ No	☐ Yes:

12. Does the patient have any other known diagnoses or special needs? Please list: _____

_____

_____

13. Did the patient have newborn screening (PKU test) completed:

    □ No
    □ Yes: □ Normal □ Abnormal (please explain): _____

14. For the parents of the patient: Were there any problems during the pregnancy or the birth of this child?

    □ No □ Yes (please explain): _____

    _____

About the Parents of the Patient

1. Are the patient's parents related by blood (example – 1st cousins, 2nd cousins, etc.)?

    □ No □ Yes (please explain): _____

2. Are the patient's grandparents related by blood (example – 1st cousins, 2nd cousins, etc.)?

    □ No □ Yes (please explain): _____

3. Has the mother of the patient had any of the following (please specify how many of each)?

    □ Miscarriages: _____ Stillbirths: _____

4. Please complete the table below. Please refer to the table on page 1 to help guide your answers about health issues or special needs.

Relative	**Status**	**Age (or age deceased)**	**Health issues or special needs**
Father	□ Living □ Deceased		
Mother	□ Living □ Deceased		

About the Brothers and Sisters of the Patient

1. How many full siblings (same mother and same father) does the patient have?

    Brothers: _____ Sisters: _____

2. Are any of these brothers or sisters a twin to the patient or to each other?

    □ No □ Yes (please explain): _____

3. Does the patient have any half-brothers or half-sisters from a different father?

    □ No □ Yes (please list): # half-brothers _____ # half-sisters _____

4. Does the patient have any half-brothers or half-sisters from a different mother?

    □ No □ Yes (please list): # half-brothers _____ # half-sisters _____

5. Does the patient have any adopted brothers or sisters?

    □ No □ Yes (please list): # adopted brothers _____ # adopted sisters _____

6. Are all of the siblings living?

   □ No (please specify): _____

   □ Yes

7. Do any of the patient's siblings have any health issues or special needs? Please refer to the table on pages 1-2 above to help guide your answers.

   □ No □ Yes (please explain below and list names and ages of any siblings described)

_____

_____

_____

About the Children of the Patient

Does the patient have any biological children?

□ No □ Yes (please list): # daughters: _____# sons _____ (please include living & deceased children)

Are all of the children living?

□ No (please specify): _____

_____

□ Yes

Are there any health concerns for any of the patient's children? Please describe:

_____

_____

_____

About the Grandparents, Aunts, Uncles, and Cousins

Please list any health issues or special needs for the people below. Please refer to the table on pages 1-2 to help guide your answers about health issues or special needs. Paternal means in the father's family. Maternal means in the mother's family. For example:
Paternal grandfather = the patient's grandfather on the father's side of the family.
Maternal cousin = the patient's cousins on the mother's side of the family.

Grandparents

Relative	**Status**	**Age (or age deceased)**	**Health issues or special needs**
Paternal grandfather	□ Living □ Deceased		
Paternal grandmother	□ Living □ Deceased		
Maternal grandfather	□ Living □ Deceased		
Maternal grandmother	□ Living □ Deceased		

Aunts, Uncles, Cousins

Relative	**How many does the patient have?**	**Are any of these people deceased? If yes, please explain and include age and cause of death**	**Health issues or special needs for any of these relatives?**
Paternal Aunts			
Paternal Uncles			
Paternal Cousins			
Maternal Aunts			
Maternal Uncles			
Maternal Cousins			

1. Is anyone else in your family listed above adopted? □ Yes □ No
2. Is there anyone else in the extended family not listed above with any special diagnoses, special needs, or other medical problems that you think may be related to the patient's special needs or health issues?

   □ No □ Yes (please specify): _____

MRN: _____

The Community Health Clinic

CONSENT FOR CLINICAL PHOTOGRAPHY

Patient Name: _____ DOB:_____

I authorize the The Community Health Clinic (CHC) and its agents to photograph only to the extent necessary, and so long as the images are used solely for purposes of (a) identifying me as a patient of the clinic; (b) for purposes of documenting my health status, diagnosis, and treatment while a patient of the clinic and (c) for sharing with other health professionals to help aid in my diagnosis and/or treatment. I also authorize Protected Health Information related to sypmtoms, lab results, current treatment regimens, and other information the physician or nurse practitioner deems necessary to share to aid in diagnosis and/or treatment management to be used in conjunction with my photograph.

The purpose of this form is to obtain my prior written consent so that CHC may photograph or use a photograph of my likeness to aid in diagnosis and/or treatment management. Consent can be given or revoked at any time.

☐ **I consent to clinical photography.**

☐ **I do not consent to clinical photography.**

_____ _____
Patient/Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

***If a person other than the patient signs this consent form, state name and relationship to patient:**

Name: _____

Relationship: _____