SANTA YNEZ TRIBAL HEALTH CLINIC

PATIENT INFORMATION ☐ New ☐ Annual **CHART #:** _____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Gender: ☐ M ☐ F SSN#: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____

Mailing Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ **Email:** _____

ETHNICITY AND HOUSEHOLD INFORMATION

RACE: ☐ Santa Ynez Chumash ☐ Other Native American / Alaskan Indian: _____

☐ Other Chumash: _____ ☐ Other (non-Native): _____

Tribal Affiliation/Name: _____ Blood Quantum: ☐ ½ ☐ ¼ ☐ Other: _____

Father's Last Name: _____ DOB: _____ Place of Birth: _____ Tribe: _____

Mother's Maiden Name: _____ DOB: _____ Place of Birth: _____ Tribe: _____

Monthly Gross Income: $ _____ Total Family Size: _____

EMPLOYMENT INFORMATION

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Employer Name: _____ Occupation: _____ Employer Phone: _____

Employer Address: _____ City: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ Best time to call: ☐ 8a-12p ☐ 12p-5p

FINANCIAL AND INSURANCE INFORMATION

SPOUSE OR RESPONSIBLE PARTY INFORMATION:

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Last Name: _____ First Name: _____ MI: _____

DOB: _____ SSN#: _____

Address: _____ City: _____ Zip: _____

Phone: H _____ W _____ C _____ Best time to call: ☐ 8a-12p ☐ 12p-5p

INSURANCE INFORMATION:

Primary Insurance Plan: _____ ID#: _____ Group#: _____

Last Name of Insured: _____ First Name: _____ MI: _____ Date of Birth: _____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Plan: _____ ID#: _____ Group#: _____

Last Name of Insured: _____ First Name: _____ MI: _____ Date of Birth: _____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CONSENT FOR SERVICES

- As a condition of your treatment at the Santa Ynez Tribal Health Clinic, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred on their care, and financial responsibility on the part of each patient must be determined before treatment.
- Patients who carry private insurance understand that all services furnished are charged directly to the patient and that he/she is personally responsible for payment of all services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

STAFF USE ONLY:

Place stamp here:

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT, AND BY SIGNING BELOW, AGREE TO THEIR CONTENT.

Signature: _____ Date: _____

Guarantor of payment/responsible party:

Signature: _____ Date: _____

Relationship to Patient: ☐ Patient ☐ Parent/Guardian ☐ Other:

STAFF USE ONLY:

☐ Address verified by Eligibility Specialist Signature: _____

☐ CHS or Direct Status verified Signature: _____

SANTA YNEZ TRIBAL HEALTH CLINIC

Medical Health History – ADULT – please complete BOTH sides

SOCIAL HISTORY:

STATUS

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Live with significant other

Do you have children? ☐ No ☐ Yes If yes, how many? _____ Ages: _____

Highest level of education completed? _____ Occupation? _____

Current living situation? ☐ on own ☐ w/ parents ☐ w/ friends ☐ on street ☐ in shelter
☐ in foster home ☐ in boarding school ☐ other: _____

TOBACCO USE / EXPOSURE

Have you or do you:

Smoke cigarettes? ☐ No ☐ Yes If yes, _____ packs per day, for _____ # years

Smoke cigars? ☐ No ☐ Yes If yes, qty? _____ How often? _____

Chew tobacco? ☐ No ☐ Yes If yes, how often? _____

If you did smoke/chew, when did you quit? _____

Live with a smoker? ☐ No ☐ Yes If yes, for how many years? _____

ALCOHOL USE (beer, wine coolers, wine, liquor, mixed drinks, etc.)

Average number of alcoholic beverages consumed per day _____ for the past _____ # years

Alcoholic beverage of choice? _____

CAFFEINE USE

Average number cups of: ☐ Coffee: _____ cups/day ☐ Tea: _____ cups/day ☐ Cola: _____ cups/day

RECREATIONAL DRUG USE

Have you or do you:

Smoke Marijuana? ☐ No ☐ Yes Use Amphetamines? ☐ No ☐ Yes

Smoke Crack? ☐ No ☐ Yes Use Heroin? ☐ No ☐ Yes

Use Cocaine? ☐ No ☐ Yes Use Ecstasy or other designer drugs? ☐ No ☐ Yes

Use other injectable drugs? ☐ No ☐ Yes Specify: _____

If currently using, please indicate:

Type of drugs(s)?	How often?	Method (snort, shoot-up, skin pop, smoke, etc.)?

DIET AND EXERCISE

Type of exercise involved in? ☐ Walking ☐ Running ☐ Swimming ☐ Weights Other: _____

How many days/hours per week do you exercise? Days per week: _____ Hours per week: _____

What type of diet do you follow (regular, Atkins, Weight Watchers, etc.)? _____

TRAVEL

Have you traveled outside the USA in the past year? ☐ Yes ☐ No If yes, where? _____

IMMUNIZATION HISTORY: approximate year of last immunization for the following (if never, please indicate)

Hepatitis A	_____	Tetanus	_____	Pneumococcus (Pneumonia)	_____	Meningitis	_____
Hepatitis B	_____	Varicella (Chicken Pox)	_____	Measles/Mumps/Rubella	_____	HPV	_____
Polio	_____	Influenza	_____	Haemophilus Influenza B (Hib)	_____	Shingles (*elderly*)	_____

Date of last TB test? _____ ☐ Pos ☐ Neg Did you receive INH? ☐ Yes ☐ No For how long? _____

If positive, date of last chest x-ray? _____

PREVENTATIVE HEALTH:

Date of last: Complete physical? _____ Dental check-up? _____ Eye exam? _____

Wear glasses on contact lenses? ☐ Yes ☐ No Wear hearing aids? ☐ Yes ☐ No

Suffer from physical impairments? ☐ Yes ☐ No If yes, describe: _____

Do you have a current "Advance Directive" or durable "Power of Attorney" for health care? ☐ Yes ☐ No

If yes, who holds this document? _____

ACKNOWLEDGMENT:

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Updated by patient (please initial and date):

_____ _____ _____ _____ _____ _____

SANTA YNEZ TRIBAL HEALTH CLINIC

Medical Health History – ADULT – please complete BOTH sides

Last Name: _____ First Name: _____ MI: _____ Date: _____

Primary Language: _____ Place of Birth: _____ Age: _____ ☐ M ☐ F

Referring Physician/Company: _____ Phone Number: _____

MEDICAL HISTORY: list any significant medical illnesses (high blood pressure, diabetes, cancer, etc., or significant injuries (fractures)

_____

_____

_____

SURGICAL HISTORY: list any prior surgeries and approximate date of procedure

Type of Surgery:	Approximate Date of Surgery:

MEDICATION LIST: list all medications; including inhalers, nose sprays, vitamins, eye drops, birth control medications, herbal supplements and any non-prescription medications (ie: aspirin, ibuprofen, Tylenol®, cold remedies, antacids, etc.)

Medication Name:	Dose:	How Often:

ALLERGIES:

Have you ever had a bad reaction or allergy to a medication? ☐ No ☐ Yes (specify below)

Medication Name:	Reaction:

Do you have any known allergies (bee stings, food(s), etc.)? ☐ No ☐ Yes (specify below)

Allergy/Allergen:	Reaction:

FAMILY HISTORY: indicate if any close blood relative has/had any of the following

Alcoholism	☐ Y ☐ N	Who: _____	Age: ____	Anemia	☐ Y ☐ N	Who: _____	Age: ____
Arthritis	☐ Y ☐ N	Who: _____	Age: ____	Asthma	☐ Y ☐ N	Who: _____	Age: ____
Cancer	☐ Y ☐ N	Who: _____	Age: ____	Depression	☐ Y ☐ N	Who: _____	Age: ____
Diabetes	☐ Y ☐ N	Who: _____	Age: ____	Easy Bleeding	☐ Y ☐ N	Who: _____	Age: ____
Epilepsy	☐ Y ☐ N	Who: _____	Age: ____	Goiter	☐ Y ☐ N	Who: _____	Age: ____
Heart Attack	☐ Y ☐ N	Who: _____	Age: ____	High B P	☐ Y ☐ N	Who: _____	Age: ____
High Cholesterol	☐ Y ☐ N	Who: _____	Age: ____	Kidney Disease	☐ Y ☐ N	Who: _____	Age: ____
Stroke	☐ Y ☐ N	Who: _____	Age: ____	Tuberculosis	☐ Y ☐ N	Who: _____	Age: ____

SEXUAL HISTORY:

Are you having sexual relations? ☐ Yes ☐ No # of partners in the last year? Male: ____ Female: ____

Age at first sexual intercourse? _____ New sexual partners in last three (3) months? ☐ Yes ☐ No

Do you have any concerns about sexually transmitted infections/diseases? ☐ Yes ☐ No

Does your partner have other partners of the same or opposite sex? ☐ Yes ☐ No

Does your partner use injectable drugs, or is he/she at risk for HIV and/or AiDS? ☐ Yes ☐ No

Has your partner ever been treated for painful urination or discharge? ☐ Yes ☐ No

Do you have any concerns about physical or sexual abuse? ☐ Yes ☐ No

Have you had genital to genital contact? ☐ Yes ☐ No

Have you had oral-genital contact? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Have you had vaginal intercourse? ☐ Yes ☐ No

Have you had anal intercourse? ☐ Yes ☐ No

Have you ever had (please check): ☐ Chlamydia ☐ Genital Warts ☐ Gonorrhea ☐ Herpes ☐ Infertility ☐ Syphilis

TB SCREENING QUESTIONNAIRE

Today's Date: _____

Full Name: _____ Date of Birth: _____

1. Have you ever had a skin test for tuberculosis (PPD)? ☐ Yes ☐ No
   If yes, when was your most recent test? Date: _____
   What was the result? ☐ Negative ☐ Positive
2. If your TB test result was Positive, what is the date of your most recent Chest X-Ray?
   Date: _____ What was the result? ☐ Negative ☐ Positive
3. Have you ever been treated for a Positive TB test result? ☐ Yes ☐ No
   If yes, what medication(s) were you given? _____
   When were you treated? From: _____ To: _____
4. Have you ever been exposed to anyone with active Tuberculosis? ☐ Yes ☐ No
5. Have you ever lived or worked in a medical clinic or hospital, homeless shelter, drug or alcohol detox facility, or jail where you may have had direct contact with anyone infected with Tuberculosis? ☐ Yes ☐ No
6. Have you ever lived or traveled in Africa, Asia, Central America, Mexico or South America? ☐ Yes ☐ No
7. Do you have any medical illnesses of your immune system (ie: cancer, HIV (AIDS), alcohol and/or drug addiction? ☐ Yes ☐ No
8. Have you had any treatment(s) with chemotherapy or prednisone (cortisone)? ☐ Yes ☐ No
9. Have you ever received the BCG vaccine? ☐ Yes ☐ No
   If yes, when (approximate)? Date: _____

REVIEWED BY MD: TB Risk: ☐ High ☐ Low MD Initial: _____

This part to be completed by medical technician Test placed by: _____

Date of Test: _____ Dose: _____ Site: _____

Manufacturer: _____ Lot #: _____ Expiration Date: _____

Date Read: _____ Read By: _____ Result: Induration: _____ x _____ mm

Interpretation: ☐ Negative ☐ Positive Action Taken: _____

THE FORM BELOW MAY BE COMPLETED, REMOVED AND GIVEN TO THE PATIENT FOR THEIR RECORDS

Name: _____ Date: _____

TB Test (PPD) Results: ☐ Negative ☐ Positive Test Date: _____ Date Read: _____

Signature of person reading test: _____

Name of Provider or Medical Clinic: _____

Santa Ynez Tribal Health Clinic

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P: (805)688-7070 •F: (805)686-2060
E: info@sythc.org • W: www.sythc.org

Acknowledgment of Privacy Practices, Assignment of Benefits & Health Care Directives

I understand that the information provided by me and stored in my health record is necessary for the Santa Ynez Tribal Health Clinic (SYTHC) and staff, in conjunction with Indian Health Services (IHS), to provide services for my health and well-being. I understand that my health record information is securely stored either electronically or physically, and that my health record or any portion of my health record shall not be disclosed to another agency or person(s), unless specified as routine use, without my signed consent.

I, _____, acknowledge the following:
(Print patient name or parent/legal guardian name here)

☐ I have been provided the *HIPAA Privacy Act Notice* to read.
☐ I have been provided the *Patient Rights and Responsibilities Notice* to read.

I may request a copy of either form from the receptionist if I so chose.

The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, and has, from time to time, non-employed staff (students, interns, interested physicians, health care representatives, surveyors, etc.) on our premises. Normally, these non-employed staff are allowed in patient care areas for observation and/or to assist a provider.

☐ I understand that I have the option, at any time, to request that non-employed staff (students, interns and/or other professionals) be excused while I am receiving direct patient care services.

_____ **(Initial Here)**

Assignment of Benefits:

I request that payment under my medical insurance be made directly to the Santa Ynez Tribal Health Clinic. I understand that I am financially responsible when:

- My Insurance carrier does not cover a specific service;
- My insurance does not pay for services(deductible); and/or
- My insurance has been terminated.

_____ **(Initial Here)**

Health Care Proxy/Advanced Health Care Directive:

If, at anytime, I should become temporarily or permanently unable to make healthcare decisions, my healthcare proxy shall be: _____.
(Print name here)

My healthcare proxy may make all decisions about:

- My Medical, Dental, and/or Behavioral (Mental) Health Care.

Such decisions shall be consistent with my wishes, or, if my wishes are unknown, shall be consistent with my best interest.

_____ _____
Print Name of Patient | Date of Birth

_____ _____
Signature of Patient, Parent, Guardian or Patient Representative | Today's Date

_____ _____
Signature and Title of SYTHC Employee | Today's Date