

Long Valley Health Center Intake Form

Patient Information Sheet and Consent Form

Chart/Account #: _____ Date: _____

Patient Name: _____ Date of Birth: ____/____/____
Last First Middle

Mailing Address: _____ HM Phone: _____ Cell Phone: _____
(Required) (PO Box/ Street #) City State Zip

Email: _____ Veteran: Yes _____ No: _____ (Current or completed service in Uniformed Services of U.S.)

Street Address: _____ Marital Status: M S D W Gender: M F
(Street #) City State Zip (Circle your selection)

Preferred Language: _____ SS#: _____ Drivers License: State: _____ Number: _____

Employer: _____ Address: _____ Wk Phone: _____

Race/Ethnicity (Circle one): Hispanic/Latino -- Asian -- Native Hawaiian -- Other Pacific Islander -- Black/African American (including Blacks or African Americans of Latino or Hispanic Descent) -- American Indian/Alaskan Native (including American Indians or Alaska Natives of Latino or Hispanic Descent) -- White (including Whites of Latino/Hispanic Descent) -- All Others -- More than one race -- Unreported/Refused to report

Emergency Contact: _____
(Name) (Phone)

How did you hear about us? (Circle one): Newspaper Phone Book Family/Friend School Healthy Start Other

Gross Family Income: Monthly/Yearly _____ Number in Family: _____

Insurance Information

Insurance Co. _____ Name of Insured: _____ Relation to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# / ID #: _____ Group #: _____ Medi-Cal #: _____

Responsible or Insured Party if Different from Above

Insured Party Name: _____ Date of Birth: ____/____/____
Last First Middle

HM Phone: _____ Cell Phone: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

SS#: _____ Marital Status (circle one): M S D W Spouse Name, if applicable: _____

Employer: _____ Address: _____ WkPhone: _____

- Consent for Treatment:** I, the undersigned consent to the examination, immunizations, treatment and procedures for the care of the above named Patient. I understand that Physician' Assistants/Family Nurse Practitioner's (PA/NP) have been approved by the State of CA. to dispense drugs and medical supplies on the direct order of a physician or according to previously established written guidelines and that a physician is always available to the PA/NP for consultation during the assessment and treatment of patients.
- Release of Information:** To the extent necessary to determine the liability for payment and to obtain reimbursement, I authorize Long Valley Health Center to release portions of my medical records to any person, organization, or agency which is or maybe liable for all or any portion of the LVHC's charges. Including but not limited to insurance companies, health service plans, workman's compensation carriers and government agencies. The Dept. of Health Services may audit my medical records for the purpose of Center licensing or for statistical information. Such audits will not compromise the confidentiality of my medical record.
Exceptions:
- Financial Agreement:** I hereby agree that in consideration of services rendered by Long Valley Health Center to pay all bills as presented regardless of insurance coverage. I agree that if it becomes necessary the account will be referred to a collection agency and I shall pay the collection expenses in full.

Signature: _____ Date: _____ Relationship to Patient: _____
Office Use: _____ Date: _____ Title: _____

LONG VALLEY HEALTH CENTER
 PATIENT MEDICAL HISTORY

PATIENT NAME: _____

DATE OF BIRTH _____

Have you been under the care of a medical provider for the past two years: YES NO
 If yes, please give us the following information:

Physician's Name: _____ Phone # _____

Address :

Have you ever had any of the following medical illnesses or conditions?

- | | | | | |
|--------------------------|---|--|--------------------------|---|
| Yes | No | | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> Heart disease | | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy, Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> Heart attack | | <input type="checkbox"/> | <input type="checkbox"/> AIDS or HIV disease |
| <input type="checkbox"/> | <input type="checkbox"/> Heart murmur | | <input type="checkbox"/> | <input type="checkbox"/> Cancer, tumors |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic fever | | <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke, CVA, TIA | | <input type="checkbox"/> | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding/clotting problems | | <input type="checkbox"/> | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> TB, Emphysema | | <input type="checkbox"/> | <input type="checkbox"/> Sexually Transmitted disease |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma or other lung disease | | <input type="checkbox"/> | <input type="checkbox"/> Kidney bladder disease |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Other liver disease | | <input type="checkbox"/> | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> Gastritis, ulcer disease | | <input type="checkbox"/> | <input type="checkbox"/> Psychiatric diagnosis |

Do you have any other medical problem not listed above? YES NO
 If so please explain

List all medications, supplements you are taking?

Are you allergic to any medications? If yes, please list below. YES NO
 Any other allergies? If yes, please list below. YES NO

LONG VALLEY HEALTH CENTER
PATIENT MEDICAL HISTORY

Patient Name _____

CHART # _____

Any surgeries? YES NO

Any hospitalizations/ER visits? YES NO

Do you currently use, or have you ever used any of the following?

Tobacco, inhaled/chewed	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other recreational/street drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please check if you have ever had any of the following?

	Date (if known)
<input type="checkbox"/> Tetanus shot	_____
<input type="checkbox"/> Flu Shot	_____
<input type="checkbox"/> Pneumonia Shot	_____
<input type="checkbox"/> Blood Transfusion	_____
<input type="checkbox"/> TB Testing	_____
<input type="checkbox"/> Chest X-Ray	_____
<input type="checkbox"/> EKG, electrocardiogram	_____
<input type="checkbox"/> Colon cancer screening	_____
<input type="checkbox"/> Cholesterol Screening	_____
<input type="checkbox"/> Pap smear	_____
<input type="checkbox"/> Prostate Exam	_____