PATIENT REGISTRATION FORM

Patient Information			
Last Name:	**First Name:**	**Middle Name**:	
Date of Birth:	**Social Security Number:**		
If Minor, Guardian Name and Relation to Patient:			
Gender Identity: ☐ Choose not to disclose ☐ Male ☐ Female ☐ Transgender ○ Male-Female ○ Female-Male ☐ Non-Binary Preferred Pronouns: ☐ she, her, hers ☐ he, him, his ☐ they, them, theirs ☐ not listed **Preferred name** :_____ (*For billing purposes the name listed on your chart will be shown as your legal name, but office staff will make notation in your chart and make every attempt to address you by your preferred name)*			
Address: ☐ Homeless	**City:**	**State:**	**Zip Code:**
Mailing Address *if different*:			
Primary Phone: ☐ Home ☐ Cell ( )	**Alternate Phone:** ☐ Home ☐ Cell ( )		
E-Mail Address:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Other: _____			
Primary Language: **Interpreter Needed:** ☐ Yes ☐ No	**Religion:**		
Ethnicity:	**Race:** ☐ White ☐ Hispanic ☐ Native/American Indian ☐ Black-African American ☐ Asian-Pacific Islander ☐ Other:_____		
Emergency Contact			
Last Name, First Name:	**Relationship:**	**Phone Number:**	
Employment			
Employment Status ☐ Student: ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Employed: ☐ Full-time ☐ Part-time ☐ Unemployed			
Employer Name:	**Occupation:**		
Employer Address:	**Employer Phone:**		
Pharmacy Information			
Name:	**Address:**	**Phone Number:**	

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name: _____ DOB: _____

I give permission for Atiga Family Practice to provide my personal health information checked below

☐ Scheduling/Appointment information

☐ Medical information, including symptoms, diagnosis, medications, and treatment plan

☐ Health information, including symptoms, diagnosis, medications, and treatment plan regarding
(* items below must be checked, or this information cannot be given);
☐ Substance abuse ☐ Behavioral health ☐ Developmental disability ☐ HIV/AIDS

☐ Lab/Test results

☐ Billing and payment information

☐ All health information (* Protected health information items must be checked to give this information)

to the below named individuals/companies:

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.
Alternate date of expiration: _____

- I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Atiga Family Practice is permitted or required by law to release this information. For example, Atiga Family Practice may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Atiga Family Practice is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).
- I understand that this permission will remain in effect until the date stated above or until such time as I *revoke it in writing* (an updated agreement form will also revoke the validity of this specific agreement).

_____ _____
Patient/Authorized Representative Signature Date

If other than patient signing, state relationship: _____

☐ By checking this box, I agree that I am electronically signing this document.
☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically.

ANNUAL MINOR HEALTH HISTORY UPDATE

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Name of person completing form/
Nombre de la persona que completa el formulario: _____

Relationship to patient/Relación con el paciente:
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián

Home information/ Información de la casa:

Whom does the patient reside with? / ¿Con quién reside el paciente?
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián
How many people reside in the home/Cuantas personas residen en el hogar: _____
Parents are/ Los padres' son: ☐ Married/Casado ☐ Divorced/Divorciado ☐ Separated/Apartado ☐ Deceased/Fallecido
Is there drug, alcohol or smoking in the home?/¿Hay drogas, alcohol o fumar en casa? ☐ Yes/Sí ☐ No

Medical Diagnosis/Diagnóstico Médico

Have you been diagnosed with any new conditions since your last office visit?/ ¿Le han diagnosticado alguna afección nueva desde su última visita al consultorio? ☐ No

If yes, please list the date, diagnosis, and the provider or medical group who diagnosed you/
En caso afirmativo, indique la fecha, el diagnóstico y el proveedor o grupo médico que le diagnosticó:

Date of Diagnosis/ Fecha de diagnóstico	Diagnosis/Diagnóstico	Provider/Medical Group Name Nombre del proveedor/grupo médico

Surgeries/Cirugías

Have you had any surgeries since your last office visit? /¿Ha tenido alguna cirugía desde su última visita al consultorio? ☐ No

If yes, please list the date, surgery, and the name of the provider or medical group who performed it/
En caso afirmativo, indique la fecha, la cirugía y el nombre del proveedor o grupo médico que la realizó:

Date of Surgery/ Fecha de la cirugía	Surgery/Cirugía	Provider/Medical Group Name Nombre del proveedor/grupo médico

Hospitalizations/Hospitalizaciones

Have you been hospitalized (admitted as an inpatient) since your last office visit? ☐ No
¿Ha sido hospitalizado (admitido como paciente hospitalizado) en algún hospital desde su última visita al consultorio?

If yes, please list the dates you were admitted, the reason, and the name of the hospital/
En caso afirmativo, indique las fechas en que fue admitido, el motivo y el nombre del hospital:

ANNUAL MINOR HEALTH HISTORY UPDATE CONTINUED

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Dates of Stay / Fechas de estancia	Reason for Hospitalization/ Motivo de la hospitalización	Name of Hospital/ Nombre del Hospital

Vaccinations/ Vacunas:

☐ **No previous vaccinations/ Sin vacunas previas**

****PLEASE PROVIDE OFFICE WITH COPY OF PREVIOUS VACCINATION****

**** POR FAVOR PROPORCIONE A LA OFICINA UNA COPIA DE LAS VACUNAS ANTERIORES ****

and TB test documents/y documentos de prueba de tuberculosis

Screenings/Proyecciones

Date last completed/Fecha de finalización por última vez

Eye exam/Examen de la vista: _____ Hearing Screen/Pantalla de audición: _____

☐ No previous eye exam/Sin examen ocular previo ☐ No previus hearing exam/ Sin examen auditivo previo

Family History/ Historia familiar

Have any family members been diagnosed with the below since your last office visit? / ☐ None, /Nada

¿Algún miembro de la familia ha sido diagnosticado con lo siguiente desde su última visita al consultorio?

If yes, please list which family member /*En caso afirmativo,* indique qué miembro de la familia

Diabetes	
High Blood Pressure/Presión arterial alta	
Heart Disease/ Cardiopatía	
Stroke/ Carrera	
Mental Illness/ Enfermedad mental	
Cancer (Also list type/También tipo de lista)	

Do you have any new concerns you would like to discuss with your provider today? ☐ No

Signature/Firma _____

☐ By checking this box, I agree that I am electronically signing this document. / Al marcar esta casilla, acepto que estoy firmando electrónicamente este documento.

☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically./ Al marcar esta casilla, acepto que he revisado este documento, pero prefiero firmarlo manualmente en lugar de hacerlo electrónicamente.

Provider Signature/Firma del proveedor _____

ATIGA FAMILY PRACTICE

PATIENT NAME/ **DOB/** **TODAY'S DATE/**

Nombre del paciente: _____ **Fecha de nacimiento: _____** **Fecha: _____**

MEDICATIONS/MEDICAMENTOS

◯ No medications, vitamins or supplements taken/ No se toman medicamentos, vitaminas o suplementos

Please list ALL medicine you take including over the counter and supplements/
Por favor, enumere TODOS los medicamentos que toma incluyendo sobre el mostrador y suplmentos

Name/ el nombre	Dose/ la dosis	How often/ con que frecuencia	Taking for/ Tomar para	Prescriber/ Prescriptor

ALLERGIES TO MEDICATION/ALERGIAS A LA MEDICACIÓN

◯ No known allergies to medication/ No se conocen alergias a los medicamentos

Name of Medicine/ Nombre de la Medicina	Type of Reaction/ tip de reaccion

DURABLE MEDICAL EQUIPMENT/EQUIPO MÉDICO DURADERO

List any medical equipment you use at home? (Ex: CPAP, glucometer etc.)/
Enuniere cualguier equipo medico que use en casa (por ejemplo: CPAP, glucómetro, etc.)

◯ No Medical Equipment/Sin equipo médico

Periodic TB Risk Assessment

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

TB SYMPTOM REVIEW:

Do you currently have any of the following symptoms?	YES	NO
1. Cough that has lasted more than 3 weeks?	○	○
2. Coughing up blood?	○	○
3. Unexplained weight loss?	○	○
4. Chronic Fever?	○	○
5. Drenching night sweats?	○	○

(IMMEDIATE CXR AND MEDICAL EVALUATION IS NEEDED IF THE ANSWER IS YES TO ANY OF THE ABOVE)

NEW TB MEDICAL RISKS FOR TB DISEASE PROGRESSION:

Since your last office visit do you have a NEW diagnosis of:	YES	NO
1. HIV?	○	○
2. Diabetes?	○	○
3. Cancer?	○	○
4. Kidney Failure?	○	○

OR have you started taking any of the following IMMUNOSUPPRESSIVE MEDICATIONS:

1. Prednisone?	○	○
2. Methotrexate?	○	○
3. Cyclosporine?	○	○
4. Chemotherapy?	○	○
5. IV rheumatoid, psoriatic arthritis or Chron's disease medications?	○	○

NEW TB EXPOSURE RISK:	YES	NO
In the past 2 years …		
1. Have you had contact with anyone with known TB disease?	○	○
2. Have you spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe?	○	○
3. Have you been in incarcerated in either prison or jail?	○	○
4. Have you been homeless or living in a single room occupancy hotel?	○	○
5. Have you injected street drugs?	○	○
6. Have you worked with homeless persons, migrant workers or drug users?	○	○
7. Have you worked as a health care worker?	○	○

New or repeat TB test (Mantoux or blood test) is needed if the answer is YES to ANY of the above questions

REQUIRED: Document the patients Mantoux or blood test results in the medical record and database.

Provider Signature:_____

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
					Nutrition
1	Do you breastfeed your baby?				
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?				
					Physical Activity
3	Are you concerned about your baby's weight?				
4	Does your baby watch any TV?				
					Safety
5	Does your home have a working smoke detector?				
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?				
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?				
8	Does your home have cleaning supplies, medicines, and matches locked away?				
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?				
10	Do you always put your baby to sleep on her/his back?				

PATIENT NAME: _____ **DOB:** _____

11	Do you always stay with your baby when she/he is in the bathtub?				
12	Do you always place your baby in a rear facing car seat in the back seat?				
13	Is the car seat you use the right one for the age and size of your baby?				
14	Does your baby spend time near a swimming pool, river, or lake?				
15	Does your baby spend time in a home where a gun is kept?				
16	Do you give your baby a bottle with anything except formula, breast milk, or water?				Dental Health
17	Does your baby spend time with anyone who smokes?				Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?				Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date: