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 ADULT HEALTH HISTORY UPDATE

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

Medical Diagnosis/Diagnóstico Médico

Have you been diagnosed with any new conditions since your last office visit?/ ☐ No

¿Le han diagnosticado alguna afección nueva desde su última visita al consultorio?

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? ☐ No

¿Ha tenido alguna cirugía desde su última visita al consultorio?

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:

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

***Vaccinations*/ Vacunas**

Have you received any of the below vaccines since your last office visit? / ☐ No

¿Ha recibido alguna de las siguientes vacunas desde su última visita al consultorio?

Covid-19 ___/____/____ Flu/ Gripe ____/____/____ Pneumonia/ Pneumonia ____/____/____

Shingles/ Herpes ____/ ____/ ____ Tetanus/ Tétanos ____/ ____/ ____ HPV/VPH: ____/____/____

ANNUAL ADULT HEALTH HISTORY UPDATE CONTINUED

Name/Nombre:	DOB/Fecha de Nacimiento: / /

Screenings/Proyecciones

Have you completed any of the below health screenings since your last office visit? ☐ No

¿Ha completado alguno de los siguientes exámenes de salud desde su última visita al consultorio?

If yes, please list the date completed and the provider or medical group who performed/

En caso afirmativo, indique la fecha de finalización y el proveedor o grupo médico que realizó:

	Dates Completed/ Fechas de finalización	**Where/Who Performed/ Dónde/Quién actuó**
Eye Exam/Examen de la vista		
Colonoscopy/Colonoscopia		
Stool Test/Prueba de sangre oculta en heces		
Bone Density Scan/Gammagrafía de densidad ósea		
Skin Check/ Revisión de la piel		
Prostate Exam/Examen de próstata		

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)	

Social History/ Historia social:

☐ Married/ Casado ☐ Single/ Solero ☐ Separated/ Separado ☐ Divorced/ Dicorciado ☐ Widowed/ Viudo

Occupation/ Ocupación: _____

Years of education/ Años de educación: _____

Housing/ Alojamiento: ☐ Homeless/ Sin hogar ☐ Apartment or Condo ☐ Mobile Home/ Casa móvil
☐ RV/ Vehículo recreacional ☐ House/ Casa ☐ Assisted living/ Vida asistida
☐ Skilled Nursing/ Enfermería especializada ☐ Residential care/ Atención residencial
☐ Live alone/ Vivir solo ☐ Live with family or friends/ Vivir con familiares o amigos

Do you have children living with you?/ ¿Tiene hijos viviendo con usted? ☐ Yes/ Sí ☐ No How many? _____

Caffeine Use/Consumo de cafeína:

☐ Never/Nunca ☐Rarely /Raramente ☐Moderate/Moderado Amount/Day/ Cantidad/Día:_____

Name/Nombre:	**DOB/Fecha de Nacimiento:**

Drug Use/Consumo de drogas: Type Used/Tipo utilizado: _____

☐ Never/Nunca ☐ Rarely /Raramente ☐ Occasional /Ocasional ☐Daily, Amount: _____
Diario, Cantidad

Sexual Activity/ Actividad sexual:

Have you had sex in the past 12 months? / ¿Ha tenido relaciones sexuales en los últimos 12 meses?

☐ Yes/ Sí ☐ No- skip to next section/ pasar a la siguiente sección

Do you use birth control? / ¿Usas anticonceptivos? ☐ Yes/ Sí ☐ No

If yes, what type?/ Si es así, ¿de qué tipo? ☐ Condoms/ Condones ☐ Oral contraceptives/ Anticonceptivos orales

☐ IUD/ DIU ☐ Implant ☐ Shot/ Inyección ☐ Vaginal ring/ Anillo vaginal ☐ Spermicide/ Espermicida

☐ Withdraw/ Retirar ☐ Other (list)/ Otra (lista): _____

Safety/ Seguridad:

Do you need assistance with any of the following? / ¿Necesita ayuda con alguno de los siguientes? ☐ No

☐ Bathing/ Baños ☐ Dressing/ Vendaje ☐ Eating/ Comiendo

☐ Getting from bed to chair/ Ir de la cama a la silla ☐ Toileting/ Aseo

Do you have urinary and/or bowel incontinence? / ¿Tiene incontinencia urinaria y / o intestinal? ☐ Yes/ Sí ☐ No

Do you use any of the following? / ¿Utiliza alguno de los siguientes? ☐ No

☐ Cane/Caña ☐ Walker/ Caminante ☐ Scooter ☐ Hospital bed/ Cama ☐ Oxygen/ Oxígeno

☐ Wheelchair/Silla de ruedasde hospital ☐ Nighttime breathing device/ Dispositivo de respiración nocturna

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

_____

_____

_____

_____

Patient Signature/ Firma del paciente _____

☐ 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

Senior

Patient's Name (first & last)	Date of Birth / /	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *Please 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:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?		Nutrition
2	Do you eat fruits and vegetables every day?		
3	Do you limit the amount of fried food or fast food that you eat?		
4	Are you easily able to get enough healthy food?		
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?		
6	Do you often eat too much or too little food?		
7	Do you have difficulty chewing or swallowing?		
8	Are you concerned about your weight?		
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?		Physical Activity
10	Do you feel safe where you live?		Safety
11	Do you often have trouble keeping track of your medicines?		
12	Are family members or friends worried about your driving?		
13	Have you had any car accidents lately?		
14	Do you sometimes fall and hurt yourself, or is it hard to get up?		
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?		
16	Do you keep a gun in your house or place where you live?		
17	Do you brush and floss your teeth daily?		Dental Health
18	Do you often feel sad, hopeless, angry, or worried?		Mental Health
19	Do you often have trouble sleeping?		

Name: _____ **DOB:** ____/____/___

20	Do you or others think that you are having trouble remembering things?		
21	Do you smoke or chew tobacco?		Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?		
23	In the past year, have you had 4 or more alcohol drinks in one day?		
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?		
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?		Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?		
27	Have you or your partner(s) had sex without a condom in the past year?		
28	Have you ever been forced or pressured to have sex?		
29	Do you have someone to help you make decisions about your health and medical care?		Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?		
31	Do you have someone to call when you need help in an emergency?		
32	Do you have other questions or concerns about your health?		Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: DOB: / / Date of Referral:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	◯	◯	◯	◯
B	Feeling down, depressed, or hopeless	◯	◯	◯	◯
C	Trouble falling or staying asleep, sleeping too much	◯	◯	◯	◯
D	Feeling tired or having little energy	◯	◯	◯	◯
E	Poor appetite or overeating	◯	◯	◯	◯
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
G	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
H	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	◯	◯	◯	◯
I	Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	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 ☐

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯
Worrying too much about different things	◯	◯	◯	◯
Trouble relaxing	◯	◯	◯	◯
Being so restless that it's hard to sit still	◯	◯	◯	◯
Becoming easily annoyed or irritable	◯	◯	◯	◯
Feeling afraid as if something awful might happen	◯	◯	◯	◯
Total Score (add your column scores)				
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 ☐

Providers signature: _____

Date: _____