UNICARE COMMUNITY HEALTH CENTER, INC.

PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print)					
Last Name	**First Name**		**MI**	**Date of Birth**	
Address	**Apt./ Unit**	**City**	**State**	**Zip Code**	
SSN _ _ _ - _ _ - _ _ _ _	**ID/ Driver's License Number**	**Birth Sex** ☐ M ☐ F	**Email Address**		

Please check primary phone ☐ Home Phone ( ) ☐ Cell Phone ( ) ☐ Work Phone ( )

Primary Language ☐ English ☐ Spanish ☐ Other:

Do you need an interpreter? ☐ Yes ☐ No

Race (check all that apply)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ White
- ☐ American Indian/ Alaska Native
- ☐ Black/ African American
- ☐ More than one race
- ☐ Unreported/ Choose not to disclose

Ethnicity
- ☐ Mexican/ Mexican American/ Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Non-Hispanic, Latino/a, or Spanish origin
- ☐ Unreported/ Choose not to disclose

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Sexual Orientation ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Other ☐ Don't know ☐ Choose not to disclose ☐ Unknown

Gender Identity ☐ Male ☐ Female ☐ Transgender Male (F - M) ☐ Transgender Female (M - F) ☐ Other ☐ Choose not to disclose ☐ Unknown

Health Insurance ☐ Medicare ☐ Medi-Cal ☐ None ☐ Other (please specify):

Are you an Agricultural Worker? ☐ Yes ☐ No
If yes, was this: ☐ Migratory ☐ Seasonal

Is one of your family members an Agricultural Worker? ☐ Yes ☐ No ***If yes, was this:*** ☐ Migratory ☐ Seasonal

Are you a Veteran of the United States Armed Forces? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If you are homeless, please indicate your living arrangement (check one):
- ☐ Homeless Shelter (safe havens, temporary overnight housing)
- ☐ Doubling Up (living with other people temporarily, move often)
- ☐ Permanent Supportive Housing (rent, no time limits)
- ☐ Unknown
- ☐ Transitional (center, community, home)
- ☐ Street (sidewalk, car, park, doorway, abandoned building)
- ☐ Other (hotel, motel, day-to-day single room occupancy)

SPOUSE OR PARENT/LEGAL GUARDIAN INFORMATION (if applicable)			
Last Name	**First Name**	**Relation to Patient**	**Date of Birth**

Please check primary phone ☐ Home Phone ( ) ☐ Cell Phone ( ) ☐ Work Phone ( )

Rev. 07/2023

UNICARE COMMUNITY HEALTH CENTER, INC.

PATIENT REGISTRATION FORM

EMERGENCY CONTACT			
Last Name	**First Name**	**Relation to Patient**	**Date of Birth**
Please check primary phone	☐ Home Phone ( )	☐ Cell Phone ( )	☐ Work Phone ( )

SLIDING FEE SCALE DISCOUNT PROGRAM

Unicare Community Health Center provides comprehensive and high-quality primary care services to persons in need, regardless of their ability to pay. At Unicare, you will not be turned away even if you do not have health insurance. Sliding Fee is a program that may offer you a discount on your medical, dental and behavioral health charges. The program sets a discount on what you pay based on the size of your family and annual income.

Household Size:_______________ Household Annual Income: $_______________ ☐ Decline

Would you like to apply for the Sliding Fee Scale Program? ☐ Yes ☐ No

PHARMACY

Name of Preferred Pharmacy: ______________________________________ Phone Number: ( )
Pharmacy Address: ____

CONSENT TO RECEIVE TELEPHONE CALLS AND SMS MESSAGES

I consent to receive telephone calls and/or SMS messages (including text messages) from Unicare Community Health Center, or others communicating on Unicare's behalf at the specific number(s) I have provided. As part of this consent, I represent and warrant the following:

(1) I am the owner or authorized user of the mobile phone number(s) identified below. I will notify Unicare immediately if I am no longer the owner or authorized user of the mobile phone number(s) identified below.
(2) Unicare or others communicating on their behalf may call and/or send SMS messages in various formats and with various contents, including but not limited to phone calls and/or SMS messages about upcoming appointments.
(3) I am solely responsible for any phone call charges and/or message and data charges associated with such phone calls and/or SMS messages.
(4) I may opt-out of receiving these communications at any time by calling my Unicare clinic. Please allow 2-3 business days for processing.

Printed Name: ______________________________________ Signature: ____

Phone Number: ( ) Alternate Phone Number: ( )

☐ I DO NOT consent to receive telephone calls and/or SMS messages (including text messages) from Unicare Community Health Center. I understand that my experience with the service(s) that rely on communications via phone calls and/or SMS messages (including text messages) may be impacted.

CONSENT TO USE THE PATIENT PORTAL/HEALOW
Unicare Community Health Center offers secure viewing and communication via your computer, cell phone, or tablet, as a service to patients who wish to view portions of their medical record and communicate with our staff and health care providers. The Patient Portal, Healow, is designed to improve provider and patient communication. Please note that all communication via Healow will be included in your permanent patient record. Once you are registered as a patient and have provided us with your secure email address, you will receive an email with a link to register. After you are registered with Healow, you will be able to: • update your contact information • view your laboratory results • view your medical summary, medication list, treatment history, and visitation dates. The following will not be accepted through Healow: • requesting appointments • requesting any medications and/or prescription refills • requesting advice on the best course of treatment for your medical problem(s) (all diagnoses will be made by your provider when you are seen for an office visit) • requests for narcotics/controlled medications. Please select only one (check box): ☐ I hereby consent to use the Patient Portal/Healow. I understand that upon registering to use Healow, I will receive a copy of the privacy and security risks and measures which will require my acceptance in order to proceed. ☐ I DO NOT consent to use the Patient Portal/Healow.

PATIENT/PARENT/LEGAL GUARDIAN ATTESTATION
I attest that I have completed this form truthfully and to the best of my knowledge. **Patient/Parent/Legal Guardian Signature:** ___________________________________ **Date:** ___________________ **Name and Relationship (if not patient):** ____

FOR OFFICE USE ONLY	
Registering Patient Service Rep:	Patient MRN:

UNICARE COMMUNITY HEALTH CENTER, INC.
GENERAL CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative hereby voluntarily consent and authorizes Unicare Community Health Center ("Unicare"), its affiliated physicians, dentists, nurse practitioners, case managers, licensed therapists, medical assistants, nursing staff, dental assistants , hygienist, psychologists, psychiatrists, and physicians assistants to provide such care and treatment, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications which may now or during the course of the patient's care be deemed advisable or necessary. I understand that in emergency situations, it may be necessary or advisable for Unicare to perform services and/or procedures that may not be fully discussed with the patient (or responsible relative and/or patient's legal representative) in advance. I consent to these services and/or procedures under those circumstances. I am aware that the practice of medicine is not an exact science and I further acknowledge that no guarantees have been made regarding the effect of any treatment or procedure on any medical condition.

RIGHT TO REFUSE TREATMENT: I understand that I have the right to make informed decisions regarding all care and treatments, and that I may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

TEACHING PROGRAMS: Unicare may participate or contract with training institutions for teaching medical students, interns, residents, healing arts students (i.e.: nursing, hygienists, x-ray technicians, dental assistants) and post-graduate students. I understand that these trainees may participate in the care provided under the supervision of qualified and licensed personnel.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, Unicare may disclose portions of the patient's financial and medical records to any person, corporation or to any agent of any such person or corporation which is or may be liable for all or any portion of Unicare's charges, including but not limited to insurance companies, employers, health service plans or Worker's Compensation carriers. Unicare may also make pertinent information available to government agencies and other health care providers as necessary to insure continuity of care and availability of health care services for the patient and the patient's family.

ASSIGNMENT OF HEALTH BENEFITS: I hereby authorize the insurance company to pay by check made out to Unicare and mail directly to Unicare the medical/dental, behavioral health and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I understand that insurance copayment/co-insurance, non- covered services and patient liability amounts are my responsibility.

FINANCIAL AGREEMENT: The undersigned agrees to pay, whether he or she signs as agent or patient, the charges incurred at Unicare in accordance with Unicare's regular rates and terms. I understand that if I am a member of a Health Maintenance Organization (HMO) and I have not secured an authorization for payment of my services, I will be held financially responsible for all unauthorized and non-covered services.

ADVANCE DIRECTIVES: Adults 18 and older have the right to: (a) give direction about their future medical care or (b) designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I understand that I have the right to change my instructions at a later date and I understand that information about advance directives is available to me upon request.
I have executed an Advance Directive: ☐ Yes ☐ No *(If yes, please provide us with a copy)*
I would like further information: ☐ Yes ☐ No

CONSENT TO FOLLOW-UP: I understand that Unicare may contact me regarding my medical/dental status and to ask questions concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide Unicare with pertinent statistical information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) NOTICE OF PRIVACY PRACTICES:
I have received information about the HIPAA Notice of Privacy Practices (NPP) and acknowledge my receipt of this documentation. I am the patient or I am authorized to sign this form. I have received a copy of it and accept its terms.

I have read, understood and agree with all of the above statements (initials) ________

____	____
PATIENT NAME (PRINT)	PARENT/LEGAL GUARDIAN NAME (PRINT)
____	____
PATIENT SIGNATURE	PARENT/LEGAL GUARDIAN SIGNATURE
_______________	______________
DATE	DATE
____	
WITNESS NAME (PRINT)	
____	
WITNESS SIGNATURE	

ADULT HEALTH HISTORY:

Name/Nombre:	Age/Edad:	D.O.B./Cuando Nacio:	Date/Fecha:

HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion.................	No	Yes/Si	Rheumatic fever/Fiebre Reumatica.........................	No	Yes/Si
Mumps/Paperas.......................	No	Yes/Si	Heart Disease/Enfermedad del Corazon................	No	Yes/Si
Chickenpox/Viruela..................	No	Yes/Si	Tuberculosis...	No	Yes/Si
Diabetes....................................	No	Yes/Si	Venereal Disease/Enfermedad Veneria..................	No	Yes/Si
Strokes/Embolio.......................	No	Yes/Si	Serious Disease/Enfermedad Graves......................	No	Yes/Si

Ever hospitalized/Ha sido hospitalisado.................... No Yes/Si Explain/Explicacion____________________________________

Ever had surgery/Ha tenido operaciones.................. No Yes/Si Explain/Explicacion____________________________________

Had broken bones/Ha tenido fracturas..................... No Yes/Si Explain/Explicacion____________________________________

Head concusiions or injuries/Glopes o Heridas de cabeza.. No Yes/Si Explain/Explicacion____________________________________

Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetno____

Date of Last PAP Smear/La Fecha de papanicolou exam de cancer____

Date of Last Mammogram/Mammographia____

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer...	No	Yes/Si	Who/Quien?____
Diabetes...	No	Yes/Si	Who/Quien?____
Tuberculosis..	No	Yes/Si	Who/Quien?____
Heart trouble/Enfermedad del Corazon....................	No	Yes/Si	Who/Quien?____
High blood pressure/Presion alta..............................	No	Yes/Si	Who/Quien?____
Stroke/Embolio...	No	Yes/Si	Who/Quien?____
Convulsions/Epilepcia..	No	Yes/Si	Who/Quien?____
Suicide/Suicidio..	No	Yes/Si	Who/Quien?____

SOCIAL HISTORY/HISTORIA SOCIAL:

☐ Single/Soltero ☐ Married/Casado ☐ Separated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo

Alcoholic Beverages/Bebidas Alcolicas: ☐ Never/Nunca How much/Cuanto________________________________

Tobacco or Cigarettes/Tobacco o Cigarillos: ☐ Never/Nunca How much/Cuanto________________________________

Are you sexually active?/Este sexualmente activa? ☐ Yes ☐ No

What is your job?/Cual es su trabajo?____

Education Level/Nivel de Education: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 College/Colegio Supenor: ☐ 1 ☐2 ☐3 ☐4

Race/Raza: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐American Indian ☐White ☐African American ☐More than 1 Race ☐Other

Ethnicity/Étnicidad: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary language (lenguaje primario)______________________ Secondary language (lenguaje secundaria)______________________

SYSTEMIC REVIEW GENERAL? REVISION DE SYSTEMAS:

Recent weight change?/Reciente cambio de peso?.. No Yes/Si

Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?...................... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel..	No	Yes/Si	Explain/Explicacion__________________________________
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nanz-Garganta...	No	Yes/Si	Explain/Explicacion__________________________________
Neck/Cuello...	No	Yes/Si	Explain/Explicacion__________________________________
Lungs/Pulmones...	No	Yes/Si	Explain/Explicacion__________________________________
Heart and Circulation/Corazon o Circulacion....	No	Yes/Si	Explain/Explicacion__________________________________
Blood/Sangre...	No	Yes/Si	Explain/Explicacion__________________________________
Emotions/Emociones...	No	Yes/Si	Explain/Explicacion__________________________________
Nerves/Nervios..	No	Yes/Si	Explain/Explicacion__________________________________
Muscles and Bones/Estomago o Intestinos......	No	Yes/Si	Explain/Explicacion__________________________________
Sex Organs/Organos Sexuales...........................	No	Yes/Si	Explain/Explicacion__________________________________
Urinary/Unnanos...	No	Yes/Si	Explain/Explicacion__________________________________
Any other/Cualquiera otro................................	No	Yes/Si	Explain/Explicacion__________________________________

ALLERGIES OR REACTIONS TO FOOD/MEDICATION/LATEX? (ALLERGIAS O REACIONES A ALIMENTOS/MEDICINAS/LATEX?)

____

If applicable, list all current medications (lista de medicamentos actuales)____

____

PATIENT SIGNATURE/FIRMA____ DATE/FECHA____________________

DOCTOR SIGNATURE/FIRMA____ DATE/FECHA____________________

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ______________________________

DATE OF BIRTH ____/____/____ (month / day / year)

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

		yes	no	don't know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine ingredient, or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4.	Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6.	Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7.	In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10.	Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11.	Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

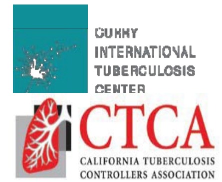
FORM COMPLETED BY ______________________________ DATE __________

FORM REVIEWED BY ______________________________ DATE __________

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

California Adult Tuberculosis Risk Assessment



- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are **new risk factors** since the last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the boxes below are checked.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe
- If resources require prioritization within this group, prioritize patients with at least one medical risk for progression (see the California Adult Tuberculosis Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥2 years old

☐ **Immunosuppression,** current or planned

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

Treat for LTBI if LTBI test result is positive and active TB disease is ruled out.

☐ **None**; no TB testing is indicated at this time.

Provider Name: ____________________________

Assessment Date: __________________________

Patient Name: ______________________________

Date of Birth: ______________________________

See the California Adult Tuberculosis Risk Assessment User Guide for more information about using this tool. To ensure you have the most current version, go to the TB RISK ASSESSMENT page (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx)