

DATE: \_\_\_\_\_

TRUECARE™

# PATIENT CONSENT TO TREAT FORM

Patient Name			DOB	Sex	Social Security Number
First	Middle	Last	mm/ dd /yy	M F	- -
Address ( <input type="checkbox"/> Same as Guarantor)			Phone Number ( <input type="checkbox"/> Same as Guarantor)		

## ACKNOWLEDGMENT OF RECEIPT OF TrueCare WELCOME PACKET

We understand that information about you and your health is confidential, and we are committed to protecting your health information. As a patient you are required to review and sign this consent form prior to receiving care. Your authorization allows TrueCare staff to use your health information for treatment, payment, and our health care operations. Additional information regarding protection of your medical information can be found in the Notice of Privacy Practice that is included in this packet or may be found on our TrueCare website.

Please initial beside each item that you have reviewed and understand. Items contained in the Welcome Packet are available on the TrueCare website, [www.truecare.org](http://www.truecare.org) for your reference. Welcome Packets are provided to new patients, however, if you would like one or have any questions, please ask for assistance from our front desk employees.

## NOTICE OF PRIVACY PRACTICES

( ) Initials I have received a copy of the Notice of Privacy Practices, or a copy was made available to me.

## CONSENT FOR TREATMENT, REFUSAL OF TREATMENT, and DISCLOSURE OF HEALTH INFORMATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its assigned clinical staff to administer and perform all medical treatment, diagnostic, surgical or other services deemed advisable or necessary for healthcare. This care may be delivered either in person or through a virtual health modality. I understand that I have the right to refuse treatment at any time. I can do so by signing a *REFUSAL OF TREATMENT* form. I also give consent to use and disclose health information necessary for treatment and payment and other healthcare operations.

**Minor (Patient who are <18 years of Age),** Please list both parents or legal guardians:

Mother Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Father Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Other, Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

## CONSENT FOR ELECTRONIC COMMUNICATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff to communicate with me via my MyChart account by providing visit summaries and Lab results electronically, as well as sending and receiving secure messages. I understand that web-based communication is offered as an option, and I may choose not to register with MyChart.

DATE: \_\_\_\_\_

Patient Label

### CONSENT FOR COMMUNICATION

( ) Initials I, (the patient, responsible party, or authorized caregiver), authorize TrueCare and its clinical staff and any affiliate or agent of TrueCare to contact me or others identified below as a member of my health support group on our cell phones and/or home phones, using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer assisted technology. I understand that my service provider may charge for such calls. I understand that I am not required to consent to such calls or messages as a condition of receiving medical service. If I do not wish to receive communications at the address or phone number above, I will ask a TrueCare staff member to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

### CONSENT TO RECEIVE HEALTH CARE SERVICE VIA TELEHEALTH

( ) Initials I, (the patient, responsible party, or authorized caregiver) understand that I have the right to access services through an in-person, face to-face visit or through telehealth. I understand there are Translation services and Transportation services available for services received through TrueCare. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future. I understand that I have options to receive services in person face-to face or via telehealth. If I choose to receive services from TrueCare now or in the future via telehealth, I understand there may be potential limitations and risks related to receiving services via telehealth as compared to an in-person visit. If I have additional questions related to telehealth services, I understand the importance of addressing them with a TrueCare staff.

### PERMISSION TO SHARE HEALTH INFORMATION (Optional)

As your healthcare team, we may need to contact you about your health. We would like to invite you to include members of your family and/or others to be part of your health support group. The people you identify below will be permitted to discuss your health information, including but not limited to appointment information, lab results, medication instructions, and referrals information, and they may be contacted for follow-up in case we are unable to reach you. Please provide accurate information for any individuals designated as part of your health support group. Designated persons must show valid photo ID when in a clinic. **To request a paper copy, please complete the AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION form.**

Last Name, First Name	Date of Birth MM/DD/YYYY	Contact Information		Relation to Patient	*Sensitive Health Information
		Phone #			<input type="checkbox"/> Yes <input type="checkbox"/> No
		Address			
		Phone #			<input type="checkbox"/> Yes <input type="checkbox"/> No
		Address			

\*Permission to **Share Sensitive Health information** includes mental health treatment information, HIV test results, alcohol, or drug treatment information.

### AFFIRMATION OF UNDERSTANDING

My signature below confirms my understanding of TrueCare Consent to Treat.

Patient's/ Parent or Legal Guardian Signature

Date:

Relationship to Patient: \_\_\_\_\_ \*Copy of legal documents must be scanned into patient's account.

TrueCare USE ONLY		
<input type="checkbox"/> <b>Verbal Consent obtained during Virtual Visit.</b> By Signing below, I acknowledge I have reviewed each section with the patient and "Obtained Verbal" consent to sign on the patient's behalf.		
TrueCare Staff Name (PRINT)	Sign	Date

# ASSIGNMENT OF BENEFITS FORM

Date: \_\_\_\_\_

Assignment of Benefits (AOB) is your agreement that helps TrueCare navigate the payment process based on the information provided. If you are insured, it gives TrueCare permission to file a claim and collect insurance payments. **TrueCare will use the following information to verify eligibility and financial liability for the services provided. If services are not covered by the insurance, then this information also helps us assess whether you might qualify for discounts or state programs.**

- You will need to identify a **Guarantor**; the guarantor is the person or entity who is financially responsible for payment on a patient's account. The Guarantor will receive all notifications referencing claims and billing statements.
- Assigning a Guarantor in the registration system will link all associated accounts. Therefore, it is important that **you list dependents** in your household who are TrueCare patients. Doing so will help TrueCare staff identify you as the Guarantor in the registration system for each Individual listed.
- We verify the guarantor's identity to make sure we don't inadvertently bill the incorrect person for Balances related to the patient's services.

Guarantor Name (Financially Responsible)			DOB mm/dd/yy	Social Security Number
First	Middle	Last	mm/ dd /yy	- -
Insurance Company			Subscriber/Member ID:	Group #:
Is the Guarantor a TrueCare Patient <input type="checkbox"/> Yes <input type="checkbox"/> No				

MAILING Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

HOME Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

☐ Same as mailing address

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

☐ Cell ☐ Home ☐ Other: \_\_\_\_\_ ☐ Cell ☐ Home ☐ Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Only list Dependents in Household who are TrueCare Patients, the total number supported is documented on next page:			
Last Name, First Name	Date of Birth mm/dd/yy	Relation to Patient	Insurance Company ID & Group # (N/A= if non applicable)

# ASSIGNMENT OF BENEFITS FORM

<b>Date:</b> mm/ dd /yy	<b>Guarantor Name:</b> First Middle Last	<b>Date of Birth:</b> mm/ dd /yy
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## Eligibility Determination for Sliding Fee Discounts

It is TrueCare's policy to provide essential services to all patients regardless of the patient's ability to pay. Discounts offered are based on the information you provide regarding your family size and income. In order to qualify for the Sliding Fee Discount Program, you will need to declare your income annually or whenever there is a change in your family size or income. This information is strictly confidential and cannot be released without your permission. If you are eligible for a sliding fee discount, it will apply to all services received at TrueCare, but not for those services provided at non-TrueCare facilities. The above statement applies to all household members who are dependents. You acknowledge that you are financially responsible for each dependent member of your household as their Guarantor.

**Please complete the following information, (\*We recommend that you provide information, even if you have insurance)**

**My family size** (the number in my household supported by this income), including myself, is \_\_\_\_\_.

Household Income, Total **Gross Annual Income**, Before Taxes is \$ \_\_\_\_\_.

**TrueCare Eligibility for Sliding Fee Discounts**, please select one and initial:

**I am interested** in seeing if I qualify for TrueCare's Slide Fee Discount Program, I have

- ☐ **Self- Declared**, Patient/Guarantor does not have proof of income at this time, will provide it at or before the next appointment. (\_\_\_\_) Initials
- ☐ **Verified**, Proof of income provided, verified by staff, copy scanned to patient chart. (\_\_\_\_) Initials

**I am declining** to provide information on my income and family size and agree to pay the full TrueCare fee.

- ☐ **Refused Application**, Patient/Guarantor is not interested in discounted services at this time. (\_\_\_\_) Initials

## ASSIGNMENT OF BENEFITS

I authorize my healthcare plan/program to reimburse TrueCare for all services I receive. I understand I am responsible for any unpaid balances, co-pays, co-insurance, deductibles, and/or any non-covered services.

- ☐ If insured, Health insurance card(s) provided: Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_

## GUARANTOR/PATIENT'S AFFIRMATION OF INFORMATION

I affirm that the information I have provided to TrueCare is accurate and true to the best of my knowledge. My signature below confirms my understanding of the following:

- **The above statement applies to all household members listed,**
- **I acknowledge that I am financially responsible for each dependent individual listed as their Guarantor.**
- If I have provided false information, I may be disqualified from the Sliding Fee Discount Program.
- **ACCEPTABLE PROOF OF INCOME (Paycheck Stub(s) or Tax Returns) IS REQUIRED FOR THE SLIDING FEE DISCOUNT PROGRAM. IF YOUR FINANCIAL SITUATION CHANGES, PLEASE KEEP TrueCare INFORMED.**
- If any information provided on this form changes, I must advise staff at, or before my next appointment.
- TrueCare does not provide refunds for professional services rendered.

**Guarantors/Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent, Guardian, Power of Attorney, or Caregiver). \*Copy of legal documents must be scanned into patient's account.

## TrueCare Staff Use:

- ☐ **Tele Visit**, I obtained verbal consent to sign on behalf of the patient during virtual visit.
- ☐ **AOB** Copies scanned to patient's account associated to Guarantor.

### TrueCare USE ONLY

By signing below, I am certifying that this form has been verified for completeness and Guarantor and associated patient's accounts have been updated.

TrueCare Staff Name (PRINT) \_\_\_\_\_ Sign \_\_\_\_\_ Location \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

## ADULT, ADOLESCENT, & FAMILY PLANNING HISTORY FORM

Date: \_\_\_\_\_

If we need to contact you to report an abnormal lab test, may we contact you at home? ☐ Yes ☐ No

If no who may we contact? \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

In a medical emergency whom shall we contact? \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Relationship \_\_\_\_\_

Do they know you are a patient here? ☐ Yes ☐ No

### FAMILY HISTORY

Has anyone in your family had trouble with any of the following:

Yes	No	Who		Yes	No	Who	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis or Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tb or lung problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Birth Defects
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Attack before age 50	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Attack after age 50	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer of _____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke before age 50	<input type="checkbox"/>	<input type="checkbox"/>	_____	Did your mother take DES while pregnant with you?
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke after age 50				

### MEDICAL HISTORY

Yes	No	When		Yes	No	When	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart attack or problems/Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis B vaccinated
<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease/Urine problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gall bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia/Sickle Cell/Blood problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	German Measles
<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chlamydia/Gonorrhea/Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy/Seizure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Herpes
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma/Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV
<input type="checkbox"/>	<input type="checkbox"/>	_____	Positive TB Test	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast Disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent vaginal infection
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety or Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Uterine Fibroids/Uterine infection
<input type="checkbox"/>	<input type="checkbox"/>	_____	Severe Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Abnormal PAP smear/Colposcopy

Have you ever had any operations? ☐ Yes ☐ No

Do you take medications regularly? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No

Are you allergic to medications? ☐ Yes ☐ No

Are you allergic to latex products ☐ Yes ☐ No

What \_\_\_\_\_

What \_\_\_\_\_

How many cigarettes? \_\_\_\_\_

How many drinks? \_\_\_\_\_

Which ones? \_\_\_\_\_

Do you use street drugs? ☐ Yes ☐ No

What? \_\_\_\_\_

Do you need help with daily activities? If Yes, What? \_\_\_\_\_

### FEMALES ONLY:

First day of your last period? \_\_\_\_\_

Age your period started \_\_\_\_\_

Periods come every \_\_\_\_\_ days

Do you have ☐ Severe cramps ☐ Premenstrual tension

Your periods ☐ Irregular ☐ Regular

Your periods ☐ Light ☐ Moderate ☐ Heavy

Do you spot or bleed between periods? ☐ Yes ☐ No

Date of Last Pap \_\_\_\_\_ Normal: ☐ Yes ☐ No

### PREGNANCY HISTORY

Total number of pregnancy(ies) \_\_\_\_\_

Number of live births \_\_\_\_\_

Number of miscarriages \_\_\_\_\_

Number of abortions \_\_\_\_\_

Are you planning to get pregnant? \_\_\_\_\_

If Yes, when? \_\_\_\_\_

Are you taking Folic Acid? \_\_\_\_\_

### CONTRACEPTIVE HISTORY

Have you had any unprotected sexual intercourse in the last 2 months? \_\_\_\_\_

What contraceptive method do you currently use? \_\_\_\_\_

Do you have any problems with this method? \_\_\_\_\_

Have you missed any pills, injections, forgotten to use diaphragm or condom, or had a condom break in the last 2 months? ☐ Yes ☐ No

Check all methods that you have used in the past

Any problems with other methods? ☐ Yes ☐ No

☐ Pills

☐ Patch

☐ Nuva Ring

☐ Diaphragm

☐ IUD

☐ Condoms

☐ Injection

☐ Jelly

☐ Foam and condoms

☐ None

### SEXUAL HISTORY

Age you first engaged in sexual activity? \_\_\_\_\_

Number of sexual partners in the past two (2) years: \_\_\_\_\_

Your sexual partner(s) have been from the: ☐ Same sex ☐ Opposite sex

☐ Both sexes

Have you ever had a partner that used injectables drugs or had sex with a same sex partner? ☐ Yes ☐ No

Has anyone close to you ever hit, slapped, pushed, kicked, or physically hurt you in any way? ☐ Yes ☐ No

Has anyone ever forced you to do something sexually that you didn't want to do? ☐ Yes ☐ No

Clinician: \_\_\_\_\_

Date: \_\_\_\_\_



Patient ID sticker

Date/Fecha: \_\_\_\_\_

**TrueCare™ TUBERCULOSIS RISK ASSESSMENT**

Patient: refers to you or your child depending upon who is visiting the doctor.

High Risk Country: refers to countries other than the United States, Canada, Australia, New Zealand or countries located in Western or Northern Europe.

	YES	NO	FOR TrueCare™ STAFF USE
1. Has the <u>patient</u> had a positive tuberculosis test OR been diagnosed with tuberculosis disease?	<input type="checkbox"/>	<input type="checkbox"/>	Perform symptom check –NO PPD/QG
2. Has a family member or other person who has contact with the <u>patient</u> had a positive tuberculosis test OR tuberculosis disease?	<input type="checkbox"/>	<input type="checkbox"/>	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. Was the <u>patient</u> born in a high-risk country (see above)?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the <u>patient</u> traveled to a high-risk country (see above) for more than 3 weeks in the past year or do they cross the US-Mexico border on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the <u>patient</u> ever consumed raw (unpasteurized) milk or cheese (queso fresco) purchased outside of the United States?	<input type="checkbox"/>	<input type="checkbox"/>	PPD/QG Testing
6. In the past year, has the <u>patient</u> had close contact with someone who is homeless, abused drugs, or has been in prison (including themselves)?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has the <u>patient</u> had a high risk medical condition such as HIV, malignancy, silicosis or prolonged immune suppressing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	

*Note: HIV positive patients need annual tuberculosis testing.*

**EVALUACIÓN DE RIESGO DE TUBERCULOSIS DE TrueCare™**

Paciente: se refiere a usted o a su hijo/a dependiendo de quién consulte al doctor.

País de alto riesgo: se refiere a países que no sean Estados Unidos, Canadá, Australia, Nueva Zelanda ni países ubicados en Europa del Norte u Occidental.

	SI	NO	SOLO PARA PERSONAL DE TrueCare™
1. ¿Ha tenido el/la <u>paciente</u> una prueba positiva de tuberculosis O se le ha diagnosticado tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	Perform symptom check- No PPD/QG
2. ¿Algún miembro de la familia u otra persona que tiene contacto con el/la <u>paciente</u> ha tenido una prueba de tuberculosis positiva O diagnosticado con tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. ¿El/la <u>paciente</u> nació en un país de alto riesgo (ver definición arriba)?	<input type="checkbox"/>	<input type="checkbox"/>	
4. ¿El/la <u>paciente</u> ha viajado a un país de alto riesgo (ver definición arriba) por más de 3 semanas en el último año o cruzan la frontera de USA-México de forma regular?	<input type="checkbox"/>	<input type="checkbox"/>	
5. ¿El/la <u>paciente</u> ha consumido alguna vez quesos (queso fresco) o leche cruda (sin pasteurizar) que se haya comprado fuera de los Estados Unidos?	<input type="checkbox"/>	<input type="checkbox"/>	PPD/QG Testing
6. En el último año, ¿El/la <u>paciente</u> ha tenido contacto cercano con una persona sin hogar, que ha abusado drogas o que ha estado en prisión (incluso ellos mismos)?	<input type="checkbox"/>	<input type="checkbox"/>	
7. ¿El/la <u>paciente</u> ha tenido una condición médica de alto riesgo como VIH, malignidad, silicosis o terapia inmunodepresora prolongada?	<input type="checkbox"/>	<input type="checkbox"/>	

*Nota: los pacientes con VIH positivo deben hacerse la prueba de tuberculosis anualmente.*

Patient Signature /Firma del Paciente: \_\_\_\_\_ Clinician Signature: \_\_\_\_\_

**FOR TrueCare™ STAFF USE/SOLO PARA PERSONAL DE TrueCare™ — PROBING QUESTIONS/NOTES FOR “YES” ANSWERS**

Q1&2: Did the patient have active or latent TB and did they receive Tx or Prophylaxis and if so, did they finish treatment? Hx of BCG?  
 Have they had a CXR if no prophylaxis and if so, when? Q3: Name country Q4: Name country, length of time and when?  
 Q5: Name what, when and where Q6: Consider annual testing if repetitive exposure Q7: HIV+ requires annual testing

# Staying Healthy Assessment

## Adult

Patient's Name (first & last)		Date of Birth		<input type="checkbox"/> Female <input type="checkbox"/> Male		Today's Date	
Person Completing Form (if patient needs help)		<input type="checkbox"/> Family Member <input type="checkbox"/> Other (Specify)		<input type="checkbox"/> Friend		Need help with form? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
							<b>Clinic Use Only:</b>
							Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip			
2	Do you eat fruits and vegetables every day?	Yes	No	Skip			
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip			
4	Are you easily able to get enough healthy food?	Yes	No	Skip			
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip			
6	Do you often eat too much or too little food?	No	Yes	Skip			
7	Are you concerned about your weight?	No	Yes	Skip			
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity		
9	Do you feel safe where you live?	Yes	No	Skip	Safety		
10	Have you had any car accidents lately?	No	Yes	Skip			
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip			
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip			
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip			
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health		
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health		
16	Do you often have trouble sleeping?	No	Yes	Skip			
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use		
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip			

19	In the past year, have you had: <input type="checkbox"/> <b>(men)</b> 5 or more alcohol drinks in one day? <input type="checkbox"/> <b>(women)</b> 4 or more alcohol drinks in one day?	No	Yes	Skip	Sexual Issues
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	Other Questions
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

*If yes, please describe:*

<b><i>Clinic Use Only</i></b>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <b>Patient Declined the SHA</b>
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature:		Print Name:		Date:	
<b>SHA ANNUAL REVIEW</b>					
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	