TRUECARE™ **FACT SHEET** (form 30)

Date **<Date>**	Patient Name (First, Middle, Last) **<Patient Name>**	Patient Account # **<Pt#>**	Sex **<Gender>**	Date of Birth **<DOB>**	Social Security Number **<SSN>**
Patient Email **<Patient Email>**	Emergency Contact Name **<Emergency Contact>**		Emergency Phone #: **<Emergency Phone>**		
Primary Insurance Company **<Primary Insurance>**	Secondary Insurance Company **<Secondary Insurance>**		Medical Doctor's Name **<Provider>**		

MAILING Address: _____ Apt #: _____ City: _____ Zip: _____

HOME Address: _____ Apt #: _____ City: _____ Zip: _____
☐ Same as mailing address

Home Phone: _____ Cell Phone: _____

Email Address: _____ (confirm same as above)

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.

SLIDING FEE DISCOUNT ELIGIBILITY

To determine if you may qualify for a discount on the health services rendered it is necessary for us to ask personal questions in regards to your family size and income. This information is strictly confidential and cannot be released without your permission. 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. To determine eligibility please **select one** of the following:

☐ I declare that I do not have documentation of my family's current total income or pay stubs today and will provide it at or before my next appointment. I am self-declaring that:
My family's total Gross Monthly Income (amount earned before taxes) is $ _____.
My family size (the number in my household supported by this income), including myself, is _____.

☐ I have provided documentation of my family's current total income or pay stubs which reflects:
My family's total Gross Monthly Income (amount earned before taxes) is $ _____.
My family size (the number in my household supported by this income), including myself, is _____.

☐ I have declined the option to provide information regarding my income and understand that I will not be eligible for discounted services.

MIGRANT/SEASONAL WORKER STATUS

☐ I declare that I or someone in my immediate family earn(s) 51% or more of our income from agricultural work. Agricultural work can consist of seasonal or migrant work.

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

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. 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.

CONSENT FOR COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize TrueCare™ and its assigned clinical staff to communicate with me via letter, phone call, or text using the information provided above. If I do not wish to be communicated at the address or phone number above, I will ask a TrueCare™ staff to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

Date <Date>	Patient Name (First, Middle, Last) <Patient Name>	Patient Account # <Pt #>	Sex <Gender>	Date of Birth <DOB>	Social Security Number <SSN>

CONSENT FOR ELECTRONIC COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize TrueCare™ and its assigned clinical staff to communicate with me electronically via my MyHealth account. I understand that web based communication is a choice and I may choose to not register with MyHealth.

I give consent to the following when choosing to use MyHealth:

- To receive documents such as visit summaries
- To receive lab results electronically
- To receive secure messages from my provider and assigned clinical 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 purposes in cases when we are unable to reach you. All parties listed below who wish to access your information must provide their information accurately. Designated person must show valid photo ID when in 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	Phone #	Address	Relation to Patient	*Sensitive Health Information
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

*Sensitive health information includes mental health treatment information, HIV test results, alcohol or drug treatment information.

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 understand the following:

- If I have provided false information, I may be disqualified from the Sliding Fee Discount Program.
- 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.
- I have received a copy of the Notice of Privacy Practices, or a copy was made available to me.

Patient's Signature: _____ **Date:** _____

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

☐ Obtained verbal consent to sign on behalf of the patient during virtual visit

Relationship to Patient: _____

TrueCare™ USE ONLY		
By signing below, I am certifying that this form is verified for completeness and patient's account has been updated.		
_____	_____	_____
Print Name	Signature	Location

9/02, 7/11, 5/12, 6//13, 2/14, 7/14, 11/16, 1/18, 2/19, 8/19, 6/2020

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	
☐	☐	_____	Hepatitis or Liver problems	☐	☐	_____	Tb or lung problems
☐	☐	_____	High Blood Pressure	☐	☐	_____	Birth Defects
☐	☐	_____	Heart Attack before age50	☐	☐	_____	Diabetes
☐	☐	_____	Heart Attack after age 50	☐	☐	_____	Cancer of _____
☐	☐	_____	Stroke before age 50	☐	☐		Did your mother take DES while pregnant with you?
☐	☐	_____	Stroke after age 50				

MEDICAL HISTORY

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

Have you ever had any operations? ☐ Yes ☐ No **What** _____

Do you take medications regularly? ☐ Yes ☐ No **What** _____

Do you smoke? ☐ Yes ☐ No **How many cigarettes?** _____

Do you drink? ☐ Yes ☐ No **How many drinks?** _____

Are you allergic to medications? ☐ Yes ☐ No **Which ones?**

Are you allergic to latex products ☐ Yes ☐ No **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: _____

truecare™

Date/Fecha: _____

Patient Name/Nombre del paciente:

Patient Date of Birth/Fecha de nacimiento:

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 patient had a positive tuberculosis test OR been diagnosed with tuberculosis disease?	☐	☐	Perform symptom check –**NO PPD/QG**
2. Has a family member or other person who has contact with the patient had a positive tuberculosis test OR tuberculosis disease?	☐	☐	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. Was the patient born in a high-risk country (see above)?	☐	☐	
4. Has the patient 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?	☐	☐	
5. Has the patient ever consumed raw (unpasteurized) milk or cheese (queso fresco) purchased outside of the United States?	☐	☐	
6. In the past year, has the patient had close contact with someone who is homeless, abused drugs, or has been in prison (including themselves)?	☐	☐	PPD/QG Testing
7. Has the patient had a high risk medical condition such as HIV, malignancy, silicosis or prolonged immune suppressing therapy? *Note: HIV positive patients need annual tuberculosis testing.*	☐	☐	

EVALUACIÓN DE RIESGO DE TUBERCULOSIS

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 paciente una prueba positiva de tuberculosis O se le ha diagnosticado tuberculosis?	☐	☐	Perform symptom check- **No PPD/QG**
2. ¿Algún miembro de la familia u otra persona que tiene contacto con el/la paciente ha tenido una prueba de tuberculosis positiva O diagnosticado con tuberculosis?	☐	☐	PPD Testing or Quantiferon Gold (QG) Testing or Symptom Check as clinically indicated
3. ¿El/la paciente nació en un país de alto riesgo (ver definición arriba)?	☐	☐	
4. ¿El/la paciente 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?	☐	☐	
5. ¿El/la paciente ha consumido alguna vez quesos (queso fresco) o leche cruda (sin pasteurizar) que se haya comprado fuera de los Estados Unidos?	☐	☐	
6. En el último año, ¿El/la paciente ha tenido contacto cercano con una persona sin hogar, que ha abusado drogas o que ha estado en prisión (incluso ellos mismos)?	☐	☐	PPD/QG Testing
7. ¿El/la paciente ha tenido una condición médica de alto riesgo como VIH, malignidad, silicosis o terapia inmunodepresora prolongada? *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	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ 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:
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	Nutrition
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: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
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	Sexual Issues
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	
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	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	☐	☐	☐	☐

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: