NORTH COUNTY HEALTH SERVICES **FACT SHEET** (form 30)

Date	Patient Name (First, Middle, Last)	Patient Account #	Sex	Date of Birth	Social Security

Patient Email	Emergency Contact Name	Emergency Phone #:

Primary Insurance Company	Secondary Insurance Company	Medical Doctor's Name

HOME Address: _____ Apt #: _____ City: _____ Zip: _____

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

Home Phone: _____ Cell Phone: _____

Email Address: _____ (confirm same as above)

ASSIGNMENT OF BENEFITS

I authorize my healthcare plan/program to reimburse NCHS 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 NCHS 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 NCHS 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 NCHS staff to provide me with a *REQUEST TO CHANGE COMMUNICATION PREFERENCES* form.

Date	Patient Name (First, Middle, Last)	Patient Account #	Sex	Date of Birth	Social Security Number

CONSENT FOR ELECTRONIC COMMUNICATION

I, (the patient, responsible party, or authorized caregiver), authorize NCHS 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 North County Health Services (NCHS) 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.
- North County Health Services 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.

Relationship to Patient: _____

NCHS 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

NORTH COUNTY HEALTH SERVICES
a private non profit corporation

PEDIATRIC HISTORY FORM

PATIENT LABEL

Date: _____

Yes **No** **BIRTH HISTORY**

Where was your baby born? Scripps ☐ Tri-City ☐ Palomar ☐ UCSD ☐ Other ☐

How many days was your baby in the hospital? _____ days

☐ ☐ Was your baby born early?

If so, how many weeks early? _____Birth Weight: _____

What type of delivery did you have? Vaginal ☐ C-Section ☐ Why?_____

MEDICAL HISTORY

☐ ☐ Has your child ever been in the hospital overnight?

Where? _____Why? _____

☐ ☐ Has you child ever had any serious injuries? What?_____

☐ ☐ Has you child ever had any operations? What?_____

☐ ☐ Has your child ever been to the dentist? Last visit? _____

☐ ☐ Does your child take medication on a regular basis? What? _____

☐ ☐ Is your child allergic to any medication? _____

Who provides your child's regular care? _____

Where do you get your child's immunizations? _____

☐ ☐ Has your child ever had a positive TB test? When? _____

☐ ☐ Has your child ever had special blood tests? When? _____ What for? _____

☐ ☐ Any history of Asthma or wheezing? _____

☐ ☐ Any history of anemia? Treated? _____

☐ ☐ Does you child have other medical problems of importance? What? _____

NUTRITION

			Yes	No
☐	☐	(for infants) are you currently breastfeeding)	☐	☐ (for infants) has your child started eating solid foods?
☐	☐	(for infants) are you currently giving your child formula?	☐	☐ (for toddlers) Is your child still using a bottle?
☐	☐	(for toddlers) Does your child eat finger foods or feed himself?		
☐	☐	(for school age kids) Does your child eat fruits and vegetables daily?		
☐	☐	Do you have any concerns about your child's nutrition or eating?		

DEVELOPMENT

☐ ☐ Do you have any concerns about your child's development?

In which areas do you feel your child is having problems or you have concerns?

Speech and Language ☐ Activity and Movements ☐ Social Skills ☐ Emotions and Behavior ☐

FOR OLDER GIRLS

☐ ☐ Have you started your period? What age? _____

☐ ☐ Are they regular? What was the date of you last period? _____

FAMILY HISTORY

Please check if anyone in the family has had any of the following problems: ☐ Heart disease ☐ Diabetes ☐

Liver disease ☐ High blood pressure ☐ Kidney disease ☐ Cancer ☐ Birth disorders ☐ Anemia ☐

Severe headaches ☐ Epilepsy ☐ Mental Illness ☐ Alcoholism ☐ Drug abuse

Mother's age: _____Occupation: _____Father's age: _____ Occupation: _____

Are you a single parent? ☐ Yes ☐ No Who else provides care to your child?_____

How old are your other children? _____ How is their health?_____

What type of housing do you live in? Apartment ☐ House ☐ Share rooms ☐ with friends or relatives ☐ Other

How long have you lived there? Less than 3 mo ☐ less than 1 yr ☐ more than 1 yr ☐

Is there enough food or clothing for your family? ☐ Yes ☐ No

Do you have any beliefs that would interfere with medical care? ☐ NO ☐ Yes _____

Parent's name:_____

Clinician's signature: _____ Date: _____

Internal use only: clinicians initial and update annually:

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

NCHS
We're here for you
a californiahealth+center

Date/Fecha: _____

Patient Name/Nombre del pacient
Date of Birth/Fecha de nacimiento:
SSN/Número de seguro social:

NCHS 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 NCHS 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)?	☐	☐	
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 DE NCHS

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 NCHS
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)?	☐	☐	
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 NCHS STAFF USE/SOLO PARA PERSONAL DE NCHS — 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