

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>
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**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
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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:** \_\_\_\_\_

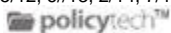
(Parent, Guardian, Power of Attorney, or Caregiver). Copy of legal documents must be scanned into patient's account.

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: \_\_\_\_\_

ADULT, ADOLESCENT, & FAMILY PLANNING HISTORY FORM

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

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:

Table with columns: Yes, No, Who, and list of conditions including Hepatitis, High Blood Pressure, Heart Attack, Stroke, and Diabetes.

MEDICAL HISTORY

Table with columns: Yes, No, When, and list of medical conditions including Heart attack, Diabetes, Blood clots, High Blood Pressure, High Cholesterol, Anemia, Migraine, Epilepsy, Asthma, TB Test, Thyroid, Anxiety, Depression, Liver problems, Hepatitis B, Kidney Disease, Prostate, Gall bladder, German Measles, Chlamydia, Herpes, HIV, Breast Disease, Frequent vaginal infection, Uterine Fibroids, Abnormal PAP smear.

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: \_\_\_\_\_



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 <u>patient</u> had a positive tuberculosis test OR been diagnosed with tuberculosis disease?	<input type="checkbox"/>	<input type="checkbox"/>	Perform symptom check – <b>NO PPD/QG</b>
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**

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- <b>No PPD/QG</b>
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

## Senior

Patient's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date
Person Completing Form <i>(if patient needs help)</i> <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Other <i>(Specify)</i>			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?  
 Yes    No

<i>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.</i>					Need Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Clinic Use Only:</i>					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	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	Physical Activity
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	Dental Health
17	Do you brush and floss your teeth daily?	Yes	No	Skip	
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

*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"/> Physical activity <input type="checkbox"/> Safety <input type="checkbox"/> Dental Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol, Tobacco, Drug Use <input type="checkbox"/> Sexual Issues <input type="checkbox"/> Independent Living	<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:	