**TRUECARE™** **FACT SHEET** (form 30)

| Date<br>**<Date>** | Patient Name (First, Middle, Last)<br>**<Patient Name>** | Patient Account #<br>**<Pt#>** | Sex<br>**<Gender>** | Date of Birth<br>**<DOB>** | Social Security Number<br>**<SSN>** |
|---|---|---|---|---|---|
| Patient Email<br>**<Patient Email>** | Emergency Contact Name<br>**<Emergency Contact>** | | Emergency Phone #:<br>**<Emergency Phone>** | | |
| Primary Insurance Company<br>**<Primary Insurance>** | Secondary Insurance Company<br>**<Secondary Insurance>** | | Medical Doctor's Name<br>**<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<br><Date> | Patient Name (First, Middle, Last)<br><Patient Name> | Patient Account #<br><Pt #> | Sex<br><Gender> | Date of Birth<br><DOB> | Social Security Number<br><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<br>mm/dd/yyyy | Phone # | Address | Relation to Patient | *Sensitive Health Information |
|---|---|---|---|---|---|
| | | | | | ☐ Yes<br>☐ No |
| | | | | | ☐ Yes<br>☐ No |
| | | | | | ☐ Yes<br>☐ 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: _____

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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.* | ☐ | ☐ | |

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## 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

## Senior

| 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 | Do you have difficulty chewing or swallowing? | No | Yes | Skip | |
| 8 | Are you concerned about your weight? | No | Yes | Skip | |
| 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 | Physical Activity |
| 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 | |
| 17 | Do you brush and floss your teeth daily? | Yes | No | Skip | Dental Health |
| 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:*

| ***Clinic Use Only*** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered |
|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ |
| ☐ Independent Living | ☐ | ☐ | ☐ | ☐ |

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: |