PHSC
Primary Health Services Center
"Champions in Health Care"

PATIENT'S CONSENT FORM

Name:	Date of Birth: (MM/DD/YY)	Age:	Chart Number:
Address:	City:	State:	Zip:
Email Address:	SS#:	Sex: ☐ Male ☐ Female	
Home Phone:	Mobile Phone No.:	Veteran Status: ☐ Veteran ☐ Not a Veteran	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Insurance Type:
☐ Medicaid
☐ Medicare
☐ Medicaid/Medicare
☐ Private

Race: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Also check below
☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race
☐ Race Unreported

	Number in Household	Monthly Income: $
Emergency Contact Person:	Relationship:	Phone Number:

CONSENT TO TREAT/PROCESS CLAIMS: I do hereby authorize PHSC or any member of their staff, under the direct supervision of appropriate licensed personnel, to provide such medical services to patients as he or she may deem reasonable and necessary to treat me, or my minor child, for any illness, condition, or disease which I am or may be afflicted.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my family physician and/or to my insurance carrier to process any and all claims. And I authorize the release of medical records from other physicians to assist in my treatment.

LABORATORY SERVICES: Please be advised that if Laboratory tests are ordered or collected that our outside laboratory will bill you for all laboratory work. If any charge went towards your insurance, it will be billed to the party (Secondary insurance/patient/patient guarantor).

ADVANCE DIRECTIVES: It is the policy of PHSC as a primary care site NOT to honor any Advance Directives a patient may possess. A minimal of basic life support efforts will be initiated by staff and EMS will be activated. The patient may invoke his/her Advance Directives after being transferred from PHSC to the nearest tertiary care site.

PATIENT RIGHTS: I have received a copy of PHSC's Notice of Privacy Practices, which makes me aware of my privacy rights and HIPAA.

Housing Status:
☐ Public Housing ☐ Own a Home ☐ Family Justice/Well Springs ☐ Rent ☐ Other

☐ Homeless (If yes, please put check mark on current situation:
☐ Transitional shelter ☐ Streets ☐ Doubled-up (Living with someone else)

Signature of Patient/Responsible Person *X*	Date:
PHSC Witness *X*	Date:

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NEW PATIENT HISTORY & PHYSICAL

Name: _____ Date of Birth: _____

Personal Medical History (Please check all that apply to you):

___ Asthma
___ Anemia
___ Arthritis
___ Autism/Asperger's
___ Atopic Dermatitis
___ ADD/ADHD
___ Anxiety
___ Bipolar
___ Cataracts
___ Cancer (Type:_____)
___ Cerebral Palsy
___ Chron's Disease
___ Chicken Pox
___ Depression
___ Dementia
___ Diabetes
___ Down's Syndrome
___ Diverticulitis
___ DVT (Deep Vein Thrombosis)
___ Enlarged Prostate
___ GERD
___ Gallbladder Disease
___ Gout
___ Glaucoma
___ Hepatitis
___ Hypertension (High Blood Pressure)
___ High Cholesterol
___ Hemorrhoids
___ Hernia
___ Heart Disease
___ Kidney Disease
___ Mental Illness
___ Pneumonia
___ Seasonal Allergies
___ Sickle Cell
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___

Admissions to Emergency Room and/or Hospital:

Year	Illness, Operation, or Childbirth	Hospital

Medication Allergies: _____

_____

What Pharmacy do you use? _____

_____

Current Medications (including any over the counter medications such as Aspirin or vitamins)

_____

_____

_____

_____

Family History:
(Please list all blood relatives. <u>Do not include yourself</u>)

___ Asthma
___ Arthritis
___ Diabetes
___ Cancer (Type:_____)
___ Stroke
___ Hypertension
___ Heart Attach
___ Kidney Disease
___ Mental Illness
___ Other:_____
___ Tuberculosis
___ Thyroid Disease
___ Glaucoma
___ Gout

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NEW PATIENT HISTORY & PHYSICAL

PERSONAL HEALTH QUESTIONS: (Please circle or fill in ALL Questions)

Sexual History:

Have you ever had sex? Yes or No
If yes, at what age did you have sex for the first time? _____
Do you feel attracted to someone of the same sex? Yes or No

Have you had sex with multiple partners? Yes or No
Do you or your partner use any birth control methods? Yes or No
Condoms Yes or No
Withdrawal or pull out method? Yes or No
Pills? Yes or No
Depo shot? Yes or No
Would you like to discuss birth control methods? Yes or No

Have you ever had an STD? Yes or No
Have you ever had lumps or sores around your penis or vagina? Yes or No
Would you like information about AIDS and safer sex? Yes or No
Have you ever thought about being tested for HIV/AIDS? Yes or No

Menstrual History

Have you had your first period? Yes or No
At what age was your first period? _____
How many days does it usually last? _____
your periods come once a month? Yes or No
Do you have paid or cramps with your period? Yes or No
Have you ever been pregnant? Yes or No
Have you ever miscarried? Yes or No
Have you ever had an abortion? Yes or No

Substance Use History

Have you ever smoked cigarettes? Yes or No
Have you ever tried marijuana? Yes or No

Have you ever tried PCP (Angel Dust)? Yes or No

Have you ever tried Cocaine? Yes or No
Have you ever tried Heroin? Yes or No
Have you ever tried Mescaline, LSD, Ecstasy? Yes or No
Have you ever tried Pills (Opiods, Benzodiazepines)? Yes or No
Have you ever tried Alcohol Yes or No

Mental Health History

Do you feel depressed or down a lot? Yes or No
If Yes, What do you do to feel better? _____
Have you ever thought about killing/hurting yourself? Yes or No

Have you ever had counseling with someone? Yes or No
If so, where? _____
Are you having problems at home? Yes or No

Sex/Physical Abuse History

Has anyone ever hit you very hard or beat you? Yes or No
Has anyone ever touched your body in a way that made you uncomfortable or was without consent? Yes or No
Did anyone ever force you or tried to force you to have sex? Yes or No

Self-Image/Diet History

Are you or have you ever been on a special diet? Yes or No
Do you think you are overweight? Yes or No
Do you think you are underweight? Yes or No
Do you ever make yourself vomit? Yes or No
Do you ever binge (really overeat)? Yes or No
Do you ever try to go a whole day without eating? Yes or No Do

Social/Environment History

Do you smoke? Yes or No
Do you drink alcohol? Yes or No
Occupation? _____
Highest grade of school completed? _____
Are you visually impaired? _____
(do you wear contacts or glasses?) _____
Do you live in a private home, apartment, or trailer/mobile home? _____
How many bedrooms? _____
Do you have your own room or share a room? _____
How many people total live with you? _____
Do you live with someone who smokes? Yes or No
Do you have fire detectors in your home? Yes or No
Do you have any pets? Yes or No