PATIENT PERSONAL INFORMATION

There is no charge for any service provided by Arubah Community Clinic and all information is confidential and is not used to determine access to care.

Today's Date: _____

Patient's Full Name ***(Please Print)***: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Current Address: _____
(STREET ADDRESS/ P.O. BOX) (CITY/ STATE) (ZIP CODE)

Gender: ☐ Male ☐ Female Date of Birth:_____-_____-_____ Social Security # XXX-XX-___ ___ ___ ___

Contact Phone #: (____)_____-_____Email _____

Household size **(including yourself)**:_____ Marital Status: Single Married Divorced Widowed

Race: ☐ White ☐ African-American ☐ Native American ☐ Asian ☐ Other: _____

Ethnicity: ☐ NOT Hispanic/Latino ☐ Hispanic/Latino

Emergency Contact:_____Relationship:_____Phone: (_____)_____-_____

Authorization to share health information with contact ☐ Yes ☐ No Other Contact: _____

IF PATIENT IS A MINOR, please provide the full name of parent(s) and/or legal guardian:

Mother:_____ Father: _____

Legal Guardian:_____(if parents are divorced or unmarried)

Is the patient covered by <u>OR</u> eligible for <u>ANY</u> of the following: *(<u>Check all that apply</u>)*

Medicaid/Sooner Care	☐ Yes ☐ No	Pending Date Applied: _____
Medicare	☐ Yes ☐ No	Pending Date Applied: _____
Indian Health Services	☐ Yes ☐ No	
Veteran's Health Services	☐ Yes ☐ No	
Private Health Insurance	☐ Yes ☐ No	
Prescription Drug Coverage	☐ Yes ☐ No	

<u>HOW DID YOU HEAR ABOUT US?</u>

HOSPITAL/ER: ____ MEDIA (TV/ RADIO): _____ INTERNET: _____ FACEBOOK: _____

COMMUNITY RESOURCE: _____ FRIEND: _____ OTHER: _____

PATIENT HISTORY

Past Medical, Family and Social History

ALLERGIES TO MEDICATIONS/ FOODS: _____

List ALL medications you are currently taking: *(Include over-the-counter and herbal meds)*

Name of Medication	Dosage	Prescribing Physician	Reason for Medication	Refill?
				Y/ N
				Y/ N
				Y/ N
				Y/ N
				Y/ N
				Y/ N

Preferred Pharmacy: _____

Personal/ Family History: (Have you or any member of your family had any of the following? If so, put the family member's relationship: self, grandmother, father, etc.)

Diabetes_____ High Blood Pressure _____ Stroke_____

Heart Attack _____ Allergies_____ Headaches_____

Heart Disease _____ Abnormal Bleeding _____ Kidney Disease _____

Stomach Problems _____ Seizure_____ Cancer _____

Joint Replacements _____ Dental Concerns _____

Social History:

Smoke/Tobacco? ☐ N ☐ Y How Much? _____ How Often? _____

Alcohol? ☐ N ☐ Y How Much? _____ How Often? _____

Illegal drugs? ☐ N ☐ Y How Much? _____ How Often? _____

Medical Marijuana? ☐ N ☐ Y How Much? _____ How Often? _____

--In Last 6 Months--

ER/Urgent Care Visits/ Hospitalizations: ☐ **Yes** ☐ **No**

Date & Name of Urgent Care/ ER/ Hospital: _____

_____

AUTHORIZATION for

Examination, Treatment, Prescriptions and MEDICAL SERVICES

Acknowledgment of

Notice of Privacy Practices

Patient Name:_____Date of Birth:_____-_____-_____

I understand the physicians and all other staff of Arubah Community Clinic are providing medical services free of charge on a voluntary basis. I understand that by providing inaccurate information or by omitting relevant information I may jeopardize my status as a patient at Arubah Community Clinic. I hereby give consent for medical care and release Arubah Community Clinic, the physicians, and all staff from any liability arising from my treatment.

I also, hereby acknowledge that I have been provided with **Arubah Community Clinic Notice of Privacy Practices** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Signature:_____Date: _____

Parent or Legal Guardian Signature: _____

NOTICE TO PATIENTS

Federal Tort Claims Act

This is to notify the patient that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (see 42 U.S.C. §233(a), (o)) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (see 42 U.S.C. §233(a), (o)).

Acknowledged:_ Patient name, printed legibly

_____

Patient Signature

_____

Parent/ Legal guardian or legal representative

SPIRITUAL HEALTH SURVEY

Research shows that spirituality or faith can have a positive impact on health. If you feel comfortable, please answer the following questions to help us understand the role of spirituality and faith in your life.

Do you attend religious services? YES NO

If YES, how often?_____times per day / week / month / year

How important is faith/spirituality to you?

Very little somewhat quite a bit a great deal

Many people seem to be living under a great amount of stress. Why do you think so?

____ Financial Pressures ____Family Pressures

____ Lack of Purpose ____Changing Moral Values

____ Uncertain Future ____Substance Abuse

____ Other _____

We have a prayer ministry. Do you have any concerns we could pray for?

_____

_____

_____

_____

*ALL INFORMATION WILL REMAIN CONFIDENTIAL**

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to **ARUBAH COMMUNITY CLINIC**, 1021 WEST MAIN ST, COLLINSVILLE, OK 74021
FAX#: 918-371-3552
Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____and_____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)