Stony Creek Community Health Center
12454 Hartley Street *P.O. Box 188 Stony Creek, VA 23882
Ph: (434) 246- 6100 Fax: (434) 246- 6614

NEW PATIENT REGISTRATION FORM

(PLEASE PRINT)

Today's Date:	PCP:

PATIENT INFORMATION

Last name:	First:	MI:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Birth date:	Sex: ☐ Transgender ☐ Male ☐ Female	Race:	SSN:
Street Address:			Home Phone:
City:	State:	Zip:	Work Phone:
Email:			Cell Phone:
Pharmacy Name:		City/County:	Pharmacy Phone:
Occupation:	Employer:		

INSURANCE INFORMATION

Primary Carrier:	Birth Date:	Address (if different):	Phone:
Subscriber's Name:	Policy No.:		Group No.:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Secondary Carrier (if applicable):	Subscriber's name:	Policy No.:	Group No.:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Person responsible for bill:		**Relationship:**	

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

I hereby authorize and request my insurance company to pay directly to the provider, the amount(s) due on a claim for services rendered to me or my dependents. I further agree should the amount be insufficient to cover the medical and/or surgical expenses, I will be responsible for payment of the difference(s), according to the explanation of benefits. If the nature of the office visit is not covered by the policy, I will be financially responsible to pay the provider the amount of the entire bill.

I hereby authorize treatment of the patient named above and agree to pay all charges at the time services are rendered, unless other arrangements are agreed upon in advance.

Patient/ Guardian Signature: ______________________ *Date:* ______________

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Name ______________________ Date ________

New Patient Health History Questionnaire

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all **six** pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank-you!

Who referred you to my practice?

Circle one: patient, family member, physician, assigned. Name?__________________

Main reason for today's visit: ______________________________

Other concerns: ______________________________

____

What are your health goals for the next year? ______________________________

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: ______________________________

____

List any medical suppliers you use (e.g. respiratory supplies, etc): ______________________________

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ **NONE**

(If yes, to what & what reaction?) ______________________________

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) ______ With Pertussis (Tdap) _______ Varicella (Chicken Pox) shot *or* illness ______ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date __________________ Result, if known __________________

Sigmoidoscopy or Colonoscopy (circle one) Date (year)______________ Abnormal? □ No □ Yes
Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where ________________ Abnormal? □ No □ Yes

Pap Smear Most recent date/where ________________ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where ________________ Abnormal? □ No □ Yes

please go to next page

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	***Now***	***Past***	***Comments***
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			

please go to next page

Personal History continued

Condition	Now	Past	Comments
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure		Yes	Year	Comments
Abdominal surgery				
Angiogram (heart)				
Angiogram (vascular)				
Appendectomy (appendix removal)				
Back surgery (lumbar)				
Biopsy (location in comments)				
Breast Biopsy				Circle: Right Left Both
Breast surgery				Circle: Right Left Both
Cataract surgery				
Colonoscopy				
Coronary Bypass				
Coronary Stent				
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)				
Gallbladder Removal				Circle: Laparoscopic (HX0271)
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix surgery)				
Neck (Spine) surgery				
Ovary Removal				Circle: Right Left Both
Pulmonary Function Test				
Sigmoidoscopy				
Sinus Surgery				
Stress Test (stress echo)				
Stress Test (thallium/perfusion)				
Stress Test (treadmill)				
Tonsillectomy				
Tubal ligation				
Vasectomy				
Other (list)				

□ **Check box if you have never had any medical procedures or surgeries.**

please go to next page

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted and you do not know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Hyperlipidemia – high cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other type										
Colon Polyp										
Diabetes Type I (childhood onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (list)										
Other (list)										

please go to next page

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked cigarettes/ pipe/ cigars (circle)? □ Never □ Yes

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _________ # of years: _________

Former smoker: Quit date: _________

Approximately how many packs/day did you smoke? _______

How many years did you smoke? ________

Other tobacco? (circle) Snuff or Chew

Quit date ________ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes

# of drinks/week: ___________ □ Beer □ Wine □ Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? ___________

Drug Use:

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? ______________________________

Quit which ones? □ All ______________________________

Any used currently? ______________________________

Please continue to next column on right

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future: □ male □ female

Birth control method or STD prevention (check all that apply):

□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring

□ Diaphragm □ Vasectomy □ Tubal ligation

□ Other method

(specify):______________________________

Other (ADL):

Military Service? □ No □ Yes

Blood Transfusion? □ No □ Yes

Exposure to toxic chemicals at work? □ No □ Yes

Exposure to toxic chemicals doing hobbies? □ No □ Yes

Diet:

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other ______________

Exercise: Do you exercise regularly? □ Yes □ No

If yes, what kind of exercise? ______________________________

____

How long (minutes)? ____________ How often? ____________

Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) □ Not applicable □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SAFETY:

Does your home have a working smoke detector? □ Yes □ No

Do you have guns in your home? □ No □ Yes

If yes, are they locked up & ammo stored separately? □ Yes □ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): ______________________________

Country of birth: ______________________________

Who lives at home with you: □ No one □ Spouse/partner □ Children ______________________________

□ Pets (what type) ______________ □ Other (roommates, extended family, etc) ______________

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

____

____

please go to next page

SOCIOECONOMIC:

Occupation (or prior occupation): ______________________________ Employer: __________________________________

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker □ other ________________

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: ____________________________

Number of children: ______ Ages (if minors): _________________ # of grandchildren: ______ # of great grandchildren: _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other ___________

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: ______

Age at beginning of periods (menstruation): ________

Age at end of periods (menopause/hysterectomy): ________ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every ______ days. How long do they last? _____ days.

Thank-you for taking the time to complete this form!

Stony Creek Community Health Center

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(Financial Policy & Patient Responsibility Notice)

Stony Creek Community Health Center provides many different types of medical services within our practice. Many insurance carriers have their own specific criteria set for how frequency an exam, test or procedure can be performed in addition to not paying for certain types of services such as routine physicals or routine/screening testing i.e. blood work etc.. Consequently, it is impossible for SCCHC to know all of the many different employer group benefits from one employer to the next. Therefore, SCCHC cannot be held responsible for informing the patient whether a particular service is covered or not. Although our staff will make every effort to try to assist you in understanding your health benefits or supplies you with other health plan related resources.

For those insurances we do participate with, we will file on your behalf directly to the insurance carrier for payment. Insurance co-payments, coinsurance, deductibles, and non-covered services are expected to be paid at the time of service. Stony Creek Community Health Center accepts cash, checks, **VISA, MASTERCARD**, and **DISCOVER**. In addition, SCCHC also offers **SLIDING FEE DISCOUNT PROGRAM** for those who do not have insurance or who have insurance with high deductibles and meet the program financial criteria. Payment arrangements are available on an individual basis.

Please note that you can set-up payment arrangements at any time, regardless of type of insurance, by speaking with a Billing or Front Office Associate at (434) 246-6100.

Additional Practice related Fees:

- **$15.00 Fee.** Request to complete LIFE, DISABILITY, FMLA, & many other various types of independent health forms and letters requiring a physician signature.
- **$25.00 Fee.** Returned checks for non-sufficient funds, which is a charge back processing fee to the patient. We will be unable to accept any personal checks until account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit cards as a method of payment for future visits.

By signing below, I acknowledge and understand the Financial Policy of Stony Creek Community Health Center and all payment terms under this Policy as well as my responsibilities as a patient t know and understand my health insurance benefits for services provided.

_______________________________ _______________________________

Signature of Patient or Person for Responsible for Account Date

_______________________________ _______________________________

Office Staff Witness Date

Stony Creek Community Health Center

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Acknowledgment of Receipt of "Notice of Privacy Practices"

I certify that I have been made aware of Stony Creek Community health Center's Notice of Privacy Practices and that I have a right to receive a copy upon request. This notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Stony Creek Community Health Center's health care operations. The Notice also describes my rights and Stony Creek Community Health Center's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of the facility. I may request that a copy be mailed to me by calling (434) 246-6100.

Stony Creek Community Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the above number and requesting a revised copy be mailed to me.

____

Signature of Patient or Personal Representative

____

Date

Stony Creek Community Health Center

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(Permission to Disclose Health Information Form)

By state law, both parents may know/review information about a minor's medical health. Only a custodial parent may authorize release of copies of medical records to a third party. Stony Creek Community Health Center will make health record disclosures that you request from other medical personnel involved in the medical treatment of the patient. After a permitted disclosure, SCCHC cannot assure that third parties will protect your confidentiality.

Please list below:

- Persons who may accompany your minor child (under 18 yrs) t see the doctor.
- Persons who may pick up prescriptions/medication on behalf of the patient.
- Persons who may pick up forms on behalf of the patient.

You have the right to restrict release of medical information by not naming any person(s).

Person(s) to whom we may release medical information

SPOUSE		**PHONE**	
PARENT(S)		**PHONE**	
GRANDPARENT(S)		**PHONE**	
OTHER		**PHONE**	
DO NOT RELEASE INFORMATION			

I understand that by naming these persons above, they can receive any/all of my medical information unless restrictions or limit are noted here: ____________________

____

Patient: (print): ____________________

Patient: (signature): ____________________

Other: (legal representative): ____________________

Date: ____________________

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CENSUS

PREFERRED METHOD OF CONTACT:

□ **Mail** □ **Home Phone** □ **Work Phone** □ **Cell Phone** □ **Email:** ____________

VETERAN STATUS:

Veteran □ *YES* Veteran □ *NO* Unreported/Refused □

SEXUAL ORIENTATION:

□ **Lesbian or Gay** □ **Bisexual** □ **Straight (not lesbian or gay)**

□ **Something Else/Don't Know** □ **Choose not to disclose**

***NUMBER OF FAMILY MEMBERS IN HOUSELHOLD:** ____________________

YEARLY INCOME:

□ Less than $10,400 □ $10,401-$15,600

□ $15,601-$18,200 □ $18,201-$20,800

□ $ Over $20,801 □ Unreported/Refused

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(Request to Release Medical Records to Stony Creek Community Health Center)

I, (patient name) ______________________________, birth date ____________________, authorize Stony Creek Community Health Center (SCCHC) to ask for and get a copy of my medical records.

Name and address of who has the medical records that I want sent to SCCHC. (**Physician, Medical Group, or Hospital**):

____

____

Phone: ______________________ **Fax:** ______________________

Send SCCHC the records for the following dates: FROM: ______________ **To:** ______________

Why I want my medical records sent to SCCHC: ______________________________

____

I understand that my right to medical record privacy and confidentially is protected by State and Federal Law. I understand that I have the rights to access my medical records and to release copies of my records to other parties of my choice in accordance with the law and policies of Stony Creek Community Health Center.

SCCHC will only release records following my authorization or as allowed or required by State and Federal Law.

This consent expires (1) one year from the signature date unless I write an earlier date here: __________

Signature of patient (legal representative) ______________________________

Printed Name: ______________________________

Date: ______________________________

Relationship to Patient: ____ **Self** ____ **Custodial Parent** ____ **Legal Guardian/Representative**

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PATIENT INFORMATION

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Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Birth date:	Sex: ☐ Transgender ☐ Male ☐ Female	Race:	SSN:
Street Address:			Home Phone:
City:	State:	Zip:	Work Phone:
Email:			Cell Phone:
Pharmacy Name:	City/County:		Pharmacy Phone:
Occupation:	Employer:		

INSURANCE INFORMATION

Primary Carrier:	Birth Date:	Address (if different):	Phone:
Subscriber's Name:	Policy No.:		Group No.:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Secondary Carrier (if applicable):	Subscriber's name:	Policy No.:	Group No.:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Person responsible for bill:		**Relationship:**	

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

I hereby authorize and request my insurance company to pay directly to the provider, the amount(s) due on a claim for services rendered to me or my dependents. I further agree should the amount be insufficient to cover the medical and/or surgical expenses, I will be responsible for payment of the difference(s), according to the explanation of benefits. If the nature of the office visit is not covered by the policy, I will be financially responsible to pay the provider the amount of the entire bill.

I hereby authorize treatment of the patient named above and agree to pay all charges at the time services are rendered, unless other arrangements are agreed upon in advance.

Patient/ Guardian Signature: ______________________ *Date:* ______________

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Name ______________________ Date

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Who referred you to my practice?

Circle one: patient, family member, physician, assigned. Name?__________________

Main reason for today's visit: ______________________________

Other concerns: ______________________________

____

What are your health goals for the next year? ______________________________

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: ______________________________

____

List any medical suppliers you use (e.g. respiratory supplies, etc): ______________________________

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ **NONE**

(If yes, to what & what reaction?) ______________________________

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) ______ With Pertussis (Tdap) _______ Varicella (Chicken Pox) shot *or* illness ______ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date __________________ Result, if known ______________________

Sigmoidoscopy or Colonoscopy (circle one) Date (year)______________ Abnormal? □ No □ Yes
Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where ______________________ Abnormal? □ No □ Yes

Pap Smear Most recent date/where ______________________ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where ______________________ Abnormal? □ No □ Yes

please go to next page

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	*Now*	*Past*	*Comments*
Alcohol / Drug abuse			
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Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis – Type A			
Hepatitis – Type B			
Hepatitis – Type C			
Hepatitis – Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure / Epilepsy			
Skin Condition (Eczema)			

please go to next page

Personal History continued

Condition	*Now*	*Past*	*Comments*
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure		*Yes*	*Year*	*Comments*
Abdominal surgery				
Angiogram (heart)				
Angiogram (vascular)				
Appendectomy (appendix removal)				
Back surgery (lumbar)				
Biopsy (location in comments)				
Breast Biopsy				Circle: Right Left Both
Breast surgery				Circle: Right Left Both
Cataract surgery				
Colonoscopy				
Coronary Bypass				
Coronary Stent				
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)				
Gallbladder Removal				Circle: Laparoscopic (HX0271)
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix surgery)				
Neck (Spine) surgery				
Ovary Removal				Circle: Right Left Both
Pulmonary Function Test				
Sigmoidoscopy				
Sinus Surgery				
Stress Test (stress echo)				
Stress Test (thallium/perfusion)				
Stress Test (treadmill)				
Tonsillectomy				
Tubal ligation				
Vasectomy				
Other (list)				

□ **Check box if you have never had any medical procedures or surgeries.**

please go to next page

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted and you do not know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Hyperlipidemia – high cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other type										
Colon Polyp										
Diabetes Type I (childhood onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (list)										
Other (list)										

please go to next page

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked cigarettes/ pipe/ cigars (circle)? ☐ Never ☐ Yes

Exposure to second hand smoke? ☐ No ☐ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _________ # of years: _________

Former smoker: Quit date: __________

Approximately how many packs/day did you smoke? _______

How many years did you smoke? ________

Other tobacco? (circle) Snuff or Chew

Quit date ________ Currently use? ☐ Yes

Are you ready to quit? ☐ No ☐ Yes

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes

# of drinks/week: ___________ ☐ Beer ☐ Wine ☐ Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? ___________

Drug Use:

Have you **ever** used recreational drugs? ☐ No ☐ Yes

If yes, which ones? ________________________________

Quit which ones? ☐ All ____________________________

Any used currently? ________________________________

Please continue to next column on right

Sexual Activity:

Are you sexually involved: ☐ Not currently ☐ Never ☐ Yes

Sexual partner(s) is/are/have been/may be in future: ☐ male ☐ female

Birth control method or STD prevention (check all that apply):

☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch ☐ Ring

☐ Diaphragm ☐ Vasectomy ☐ Tubal ligation

☐ Other method

(specify):____

Other (ADL):

Military Service? ☐ No ☐ Yes

Blood Transfusion? ☐ No ☐ Yes

Exposure to toxic chemicals at work? ☐ No ☐ Yes

Exposure to toxic chemicals doing hobbies? ☐ No ☐ Yes

Diet:

Do you follow a special diet? ☐ No ☐ Yes

vegetarian, vegan, gluten free, other _______________

Exercise: Do you exercise regularly? ☐ Yes ☐ No

If yes, what kind of exercise? __________________________

____

How long (minutes)? ____________ How often? ____________

Do you use a helmet for recreational activities? (e.g. bike, skateboard, ski) ☐ Not applicable ☐ Yes ☐ No

Do you use seatbelts consistently? ☐ Yes ☐ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? ☐ No ☐ Yes

Do you have little interest or pleasure in doing things? ☐ No ☐ Yes

SAFETY:

Does your home have a working smoke detector? ☐ Yes ☐ No

Do you have guns in your home? ☐ No ☐ Yes

If yes, are they locked up & ammo stored separately? ☐ Yes ☐ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? ☐ No ☐ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): ____________________________

Country of birth: ____

Who lives at home with you: ☐ No one ☐ Spouse/partner ☐ Children ______________________________

☐ Pets (what type) __________________ ☐ Other (roommates, extended family, etc) ____________________

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

____

____

please go to next page

SOCIOECONOMIC:

Occupation (or prior occupation): ______________________ Employer: ______________________

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker □ other ______________

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: ______________________

Number of children: _______ Ages (if minors): ______________ # of grandchildren: _______ # of great grandchildren: ______

Education: □ high school or GED □ trade school □ college □ graduate school □ other __________

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: ______

Age at beginning of periods (menstruation): _________

Age at end of periods (menopause/hysterectomy): _________ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _______ days. How long do they last? ______ days.

Thank-you for taking the time to complete this form!

Stony Creek Community Health Center

12454 Hartley Street, Stony Creek, VA 23882 Ph: (434) 246-6100 Fax: (434) 246-6614

(Financial Policy & Patient Responsibility Notice)

Stony Creek Community Health Center provides many different types of medical services within our practice. Many insurance carriers have their own specific criteria set for how frequency an exam, test or procedure can be performed in addition to not paying for certain types of services such as routine physicals or routine/screening testing i.e. blood work etc.. Consequently, it is impossible for SCCHC to know all of the many different employer group benefits from one employer to the next. Therefore, SCCHC cannot be held responsible for informing the patient whether a particular service is covered or not. Although our staff will make every effort to try to assist you in understanding your health benefits or supplies you with other health plan related resources.

For those insurances we do participate with, we will file on your behalf directly to the insurance carrier for payment. Insurance co-payments, coinsurance, deductibles, and non-covered services are expected to be paid at the time of service. Stony Creek Community Health Center accepts cash, checks, **VISA, MASTERCARD**, and **DISCOVER**. In addition, SCCHC also offers **SLIDING FEE DISCOUNT PROGRAM** for those who do not have insurance or who have insurance with high deductibles and meet the program financial criteria. Payment arrangements are available on an individual basis.

Please note that you can set-up payment arrangements at any time, regardless of type of insurance, by speaking with a Billing or Front Office Associate at (434) 246-6100.

Additional Practice related Fees:

- **$15.00 Fee.** Request to complete LIFE, DISABILITY, FMLA, & many other various types of independent health forms and letters requiring a physician signature.
- **$25.00 Fee.** Returned checks for non-sufficient funds, which is a charge back processing fee to the patient. We will be unable to accept any personal checks until account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit cards as a method of payment for future visits.

By signing below, I acknowledge and understand the Financial Policy of Stony Creek Community Health Center and all payment terms under this Policy as well as my responsibilities as a patient t know and understand my health insurance benefits for services provided.

_______________________________ _______________________________

Signature of Patient or Person for Responsible for Account Date

_______________________________ _______________________________

Office Staff Witness Date

Stony Creek Community Health Center

12454 Hartley Street, Stony Creek, VA 23882 Ph: (434) 246-6100 Fax: (434) 246-6614

Acknowledgment of Receipt of "Notice of Privacy Practices"

I certify that I have been made aware of Stony Creek Community health Center's Notice of Privacy Practices and that I have a right to receive a copy upon request. This notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Stony Creek Community Health Center's health care operations. The Notice also describes my rights and Stony Creek Community Health Center's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of the facility. I may request that a copy be mailed to me by calling (434) 246-6100.

Stony Creek Community Health Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the above number and requesting a revised copy be mailed to me.

____

Signature of Patient or Personal Representative

____

Date

Stony Creek Community Health Center

12454 Hartley Street, Stony Creek, VA 23882 Ph: (434) 246-6100 Fax: (434) 246-6614

(Permission to Disclose Health Information Form)

By state law, both parents may know/review information about a minor's medical health. Only a custodial parent may authorize release of copies of medical records to a third party. Stony Creek Community Health Center will make health record disclosures that you request from other medical personnel involved in the medical treatment of the patient. After a permitted disclosure, SCCHC cannot assure that third parties will protect your confidentiality.

Please list below:

- Persons who may accompany your minor child (under 18 yrs) t see the doctor.
- Persons who may pick up prescriptions/medication on behalf of the patient.
- Persons who may pick up forms on behalf of the patient.

You have the right to restrict release of medical information by not naming any person(s).

Person(s) to whom we may release medical information

SPOUSE		**PHONE**	
PARENT(S)		**PHONE**	
GRANDPARENT(S)		**PHONE**	
OTHER		**PHONE**	
DO NOT RELEASE INFORMATION			

I understand that by naming these persons above, they can receive any/all of my medical information unless restrictions or limit are noted here: ______________________________

____

Patient: (print): ______________________________

Patient: (signature): ______________________________

Other: (legal representative):______________________________

Date: ______________________________

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CENSUS

PREFERRED METHOD OF CONTACT:

□ **Mail** □ **Home Phone** □ **Work Phone** □ **Cell Phone** □ **Email:** ____________

VETERAN STATUS:

Veteran □ *YES* Veteran □ *NO* Unreported/Refused □

SEXUAL ORIENTATION:

□ **Lesbian or Gay** □ **Bisexual** □ **Straight (not lesbian or gay)**

□ **Something Else/Don't Know** □ **Choose not to disclose**

***NUMBER OF FAMILY MEMBERS IN HOUSELHOLD:** ____________________

YEARLY INCOME:

□ Less than $10,400 □ $10,401-$15,600

□ $15,601-$18,200 □ $18,201-$20,800

□ $ Over $20,801 □ Unreported/Refused

Stony Creek Community Health Center

12454 Hartley Street, Stony Creek, VA 23882 Ph: (434) 246-6100 Fax: (434) 246-6614

(Request to Release Medical Records to Stony Creek Community Health Center)

I, (patient name) ______________________________, birth date ____________________, authorize Stony Creek Community Health Center (SCCHC) to ask for and get a copy of my medical records.

Name and address of who has the medical records that I want sent to SCCHC. (Physician, Medical Group, or Hospital):

____

____

Phone: ______________________________ Fax: ______________________________

Send SCCHC the records for the following dates: FROM: ________________ To: ______________

Why I want my medical records sent to SCCHC: ______________________________

____

I understand that my right to medical record privacy and confidentially is protected by State and Federal Law. I understand that I have the rights to access my medical records and to release copies of my records to other parties of my choice in accordance with the law and policies of Stony Creek Community Health Center.

SCCHC will only release records following my authorization or as allowed or required by State and Federal Law.

This consent expires (1) one year from the signature date unless I write an earlier date here: __________

Signature of patient (legal representative)______________________________

Printed Name: ______________________________

Date: ______________________________

Relationship to Patient: ____ Self _____ Custodial Parent _____ Legal Guardian/Representative