SHINGLE SPRINGS Health & Wellness Center
Healthcare for All
SHINGLE SPRINGS HEALTH & WELLNESS CENTER
5168 Honpie Road
Placerville, CA 95667
Phone: 530-387-4975
www.sshwc.org

Shingle Springs Health & Wellness Center

REGISTRATION FORM

RPMS#

Patient's Legal Name _____
Last *First* *Full Middle Name*

Sex_____ Social Security Number_____ Marital Status_____

Address_____ _____ _____ _____
City *State* *Zip*

Can we send mail to the address listed above? Yes /No

Birth date_____ City & State of birth_____ When did you move here?_____

Phone _____ _____ _____
Home *Work* *Cell/Message*

☐*Call Back* ☐*Detailed Message* ☐*None* ☐*Call Back* ☐*Detailed Message* ☐*None* ☐*Call Back* ☐*Detailed Message* ☐*None*

Employer_____

Father's Name _____ Mother's Maiden Name_____
Last *First* *Last* *First*

IF PATIENT IS UNDER AGE 18

Guardian_____ **Relationship to Patient**_____

Address if different _____

Telephone _____ _____ _____
Home ***Work*** ***Cell/Message***

Father's Employer_____ ***Mother's Employer***_____

If you are a member of a Native American or Alaska Native Tribe, please provide the name of the tribe and a copy of your membership documentation. **Tribe**_____

Appointment Policy: When you have an appointment within the clinic and need to cancel or reschedule you must give a 24 hour notice or you will be marked as a ***No Show*** and charged a ***$50.00*** fee for first occurrence and $75.00 per occurrence after. We have a 5 minute grace period, if you are more the 5 minutes late to your scheduled appointment you will be considered a ***No Show*** and rescheduled accordingly.

Emergency Contact
Name_____ Phone_____

Address_____ Relationship to Patient_____

Next of Kin
Name_____ Phone_____

Address_____ Relationship to Patient_____

As a Federally Qualified Health Center and to keep our services affordable, we receive grant funding. To qualify for these resources we must collect the following information on all our clients. Please support us by answering all these questions.

Financial Responsibility

Do you have Medical _____ Dental _____ insurance or Medicare _____ Medi-Cal_____

If you are a dependent on someone else's insurance we will need the following to verify eligibility and to bill the insurance.

_____ _____ _____

Full Name *Date of Birth* *Sex*

Are you a US Veteran?____ Do you have VA benefits?_____ Branch_____ Discharged_____

Do you have an Advance Directive? **NO** if **YES**, it is in the form a ***"Living Will"*** or ***"Power of Attorney"*** or "***5 Wishes"***?

(Please Circle)

Indicate your ethnicity

[ ] Not Hispanic or Latino [ ] Hispanic of Latino [ ] Unknown

Indicate your race(s)

[ ] American Indian/Alaska Native [ ] Asian [ ] Africa American

[ ] Hispanic or Latino [ ] Native Hawaiian or Pacific Islander [ ]Filipino

[ ] White [ ] Other_____

What is your primary language (the language you speak at home)?_____

What other languages do you speak?_____

What is your preferred language?_____ Do you need an interpreter?_____

What is your religious preference?_____

Are you a migrant agricultural worker? _____ Are you a seasonal agricultural worker?_____

Are you current homeless?_____

Do you have access to the Internet? YES/NO Where: Home / Work / School / Clinic / Library / Community Center

Income Information

Number in Family _____ Monthly Income $_____ or Annual Income $_____

Release of Information / Assignment of Benefits: ***This clinic*** has my permission to release information as needed for insurance processing and for my insurance to release payment to ***this clinic.***

I HEARBY AUTHORIZE TREATMENT

_____ _____

Printed Name and Date ***Signature of Patient or Guardian***

Present: Photo Identification, Social Security Card, Native Verification, & Insurance Card(s)

Initials of Screener

Revised 03/14/2014

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New Patient Questionnaire for Pediatrics (ages 17 and under)

Note: This information is confidential and will be reviewed by the provider. The information will be used to update your medical record.

Name: _____ **Date of Birth**: _____

Current Occupation: _____ **Current Insurance:** _____

Pharmacy Location: _____ **Last Pediatrician/Provider:**_____

Reason for Leaving: _____

ILLNESS/INJURY: Does your child have or had any of the condition(s) below:						
Yes	**No**		**Yes**	**No**		
		Chicken Pox			Constipations Requiring a Doctors Visit	
		Ear Infections			Bladder or Kidney Infection	
		Problems with Ears or Hearing			Bed Wetting (over 5 years of age)	
		Blood Transfusions			Nasal Allergies	
		(Girls) Started Menstruating			Problems with Eyes or Vision	
		(Girls) Any Problems with Period(s)			Asthma/ Bronchitis/Croup/Pneumonia	
		Chronic of Recurrent Skin Problems			Heart Problems or Murmur	
		Frequent Headaches			Bipolar/Schizophrenia	
		Anemia or Bleeding Problem			Frequent Abdominal Pain	
		Seizures/Other Neurological Problems			ADHD/ ADD	
		Diabetes Problems			Thyroid Problem	
		Depression			Any Exposure to Tuberculosis?	
		Suicidal Thoughts	**Other:**			
		Post Traumatic Stress Syndrome	**Other:**			

Birth History:

Birthplace:_____

Delivery (please circle all that apply): Vaginal/ Cesarean/ Forceps/Vacuum/Trauma

Any Complications: No/Yes, If yes_____

Was delivery: ☐ On time ☐ Before 37 weeks of pregnancy ☐ After 42 weeks of pregnancy

Birth Weight:_____ Birth Length:_____

Did you nurse? Yes/No, until what age:_____ Any nursing problems?_____

Did mother have any problems or illness during pregnancy? No/Yes, if yes _____

OPERATIONS: (List names and dates of all operations you have had) ☐ NONE		
Name of Operations:	**Date & Location of Operation**	**Complications:**
Hospitalizations:	**Date & Location of Hospitalizations:**	**Reason for Admissions:**
Immunizations up to Date	Yes/ No If no, which ones are missing?	

Yes	No	School Age Children
		Has your child ever been held back or had to repeat a grade?
		Are you concerned about your child's attention span?
		Does your child like school?
		Any concerns about your child's behavior in school?
		Any concerns about how your child is doing academically?

Nutrition: Please circle what your child eats now		
Breast Milk	Citrus	Fruit
Iron	Skim Milk	Meat
Beans	Whole Milk	Chocolate
Formula	Vitamins	Eggs
Cereal	Vegetables	Kool Aid/ Pop
Any Nutritional Problems? Yes or No		
Taking Fluoride? Yes or NO		

FAMILY HISTORY: (Has any blood relative ever had any of the following?)							
Relationship	Living	Deceased, Cause Age		Relationship	Living	Deceased, Cause, Age	
			Deafness				Liver Disease
			Nasal Allergies				Eczema
			Addiction				Tuberculosis
			Kidney Disease				Mental Illness
			Bleeding Disorder				Thyroid Problem
			Diabetes b/f age 50				Heart Disease b/f age 50
			Bed Wetting after age 10				Epilepsy or Convulsions
			High Blood Pressure b/f 50				Developmental Disability
			Lung Prblm/ Asthma				Other:

SOCIAL HISTORY/ Home Environment:	
Name of Siblings?	
What adults live with you child?	
Has your child suffered trauma or loss?	
What types of pets do you have?	
Does anyone smoke in the house?	
How many hours of TV/Computer games per day?	
Favorite activities?	

ALLERGIES: (Please list type and reaction) ☐ NONE			
Name of Drug	Reaction	Name of Drug	Reaction

MEDICATIONS/ DRUGS: (Please list all medications/drug you take and their dosages) ☐ NONE			
Drug	Dosage	Drug	Dosage

The above information is true and accurate to the best of my recollection.

Patient Signature: _____ **Date:** _____

PATIENT APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

When Clinic time has been reserved for you by way of a scheduled clinic appointment, you are expected to be at the Clinic on time. For the first visit appointment, you should arrive 30 minutes prior to your scheduled appointment to complete the necessary registration and health history papers.

For those patients 18 years and older, as part of a health screening process, you can expect to have a blood pressure recording done at least annually.

We expect you to keep all your appointments. Please write down the date & times of your future appointments.

Listed below are the policies regarding missed appointments.

Please read and initial

1. _____ **No-Show:** When a patient is scheduled for an appointment and does not call into cancel nor shows up for the appointment. (Fee will be assessed)

2. _____ **Cancel without 24 Hour Notice:** When a patient is scheduled for an appointment and calls to cancel but does not give the Clinic 24 hours notice. (Fee will be assessed on a case by case basis)

3. _____ **Cancel with 24 Hour notice or more:** We understand that things can happen, however, we would ask that you do everything in your power to make up your appointments. (No fee see below*)

In an instance of 1 and 2 above, we reserve the right to charge you a $50.00 fee for your first infraction and $75.00 for all following infractions.

If I should "No-Show" for two scheduled appointments, I risk being placed on a "No-Show" Register List for a period of one year. If my name appears on the list I understand I will be:

a) Eligible only for very urgent medical situations short of an emergency and eligible for only emergency dental pain relief such as tooth extraction, with no expectation of immediate placement.

Patient Name (Please Print): _____

Signature: _____ **Date:** _____

If patient is a minor, parent or guardian signature.

Relation to Minor: _____

Witness Signature: _____ **Date:** _____

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Referral Guidelines

In order to ensure that your health care needs are met
We will need the following:

- Updated Address
- Phone Number
- Copy of Insurance Cards

Please make sure all the following are updated. If you have recently changed phone numbers, address, or insurance please make sure to let the front office know.

- Referrals can take up to **two - three weeks** for the specialist/provider to review. _____
- Urgent referrals are noted by the provider, then reviewed case by case. _____
- If we need to obtain authorization through your insurance, it can take up to **30 to 60 days.** _____
- **It is your responsibility to check on your referral. _____**

These appointments are difficult to schedule. If you have not heard from us or the specialist/providers office within **two-three weeks,** please contact our Referral Coordinator. Once the appointment is scheduled we ask that you go to the appointment. If you need to cancel, or reschedule, please contact the specialist/provider's office to do so. Please note that once we send it to the specialist/provider office for reviewing it might take longer than expected and it is out of our control.

If you do not call and inform us of any changes made we cannot put a priority on your specialist referrals and we will assist other patient referrals at the time.

Ignoring appointments or not complying with the specialist's office will result in either a referral being placed on hold for one month, or you will not be scheduled by the specialist's office again.

_____ _____

Patient Signature **Date**