HIGH COUNTRY community health

PATIENT INFORMATION

First Name:_______________MI:_____Last Name:________________________Previous Name:____________________Preferred Name: ___________

Today's Date:________________D.O.B.______________Age:___________Birth Sex:__Male__Female

SS#:__________-________-__________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other

Street Address: ____

Mailing Address (if different):__________________________________City:______________________State:____________Zip code_______________

Email Address:____________________________Phone: Home______________________Cell______________________Work_________________

If patient is a minor, give parent's or guardian's name:_________________________ Minor lives with: _______________________________________

Pharmacy Name & Phone #: ____

EMERGENCY INFO

Name:_________________________Relationship:______________Address:__________________________City, State: ___________

Home:_______________________Cell Phone:_________________Work Phone:_________________________________Ext: _________

Race

Asian:
___Asian Indian ____Chinese____Filipino
___ Japanese ____Korean_____Vietnamese
___ Other Asian
Native Hawaiian/Other Pacific Islander:
___Native Hawaiian_____Other Pacific Islander
___ Guamanian or Chamorro
____Samoan
___Black/African American
___American Indian ___White
____Decline to Answer

Ethnicity

Hispanic or Latino/a or Spanish:
___Mexican, Mexican American, Chicano/a
—— Puerto Rican______Cuban
___Another Hispanic, Latino/a or Spanish Origin
___More than one ethnicity
___Non-Hispanic or Latino/a
___Decline to Answer

Preferred Language

___English
___ Spanish
—— American Sign Language
Other: _____________

Pronouns

____ she/her
____ he/him
____ they/them
____ other:________

Sexual Orientation

_____Lesbian, gay or homosexual
_____Straight or heterosexual
_____Bisexual
_____Don't know
_____ Choose not to disclose

Gender Identity

___ Male ___Female
___ Female-to-male (FTM)/Transgender Male/Trans Man
___ Male-to-Female (MTF)/Transgender Female/Trans Women
___Genderqueer, neither exclusively male nor female
___ Choose not to disclose

Please Circle Your Answer Below:

1. Are you a U.S. Veteran? **YES or NO**
2.Are you or anyone in your family in the past 2 years been considered a Seasonal Farmworker? (A person whose source of income is earned mostly in agricultural work, without moving away from home) **YES or NO**
3.Are you or anyone in your family in the past 2 years been considered a Migrant Farmworker? (A person who has moved away from home and established a temporary home in order to work primarily in agriculture) **YES or NO**

DENTAL INSURANCE INFORMATION

☐ **See Card**

Insurance Policy Name: ________________________________ Policy Holder's Name: ___________________________

D.O.B: ____________ Group Name: ______________________________

Group #: _____________________________ Policy #: _______________________________

MEDICAL INSURANCE INFORMATION

☐ **See Card**

Primary Insurance Name: ________________________ Policy Holder's Name: _______________________________

D.O.B: ____________ Group #: _____________________________ Policy #: _____________________________

Secondary Insurance Name: __________________________________ Group #: ____________________________

PARTY RESPONSIBLE FOR PATIENT BILL (IF DIFFERENT THAN PATIENT)

Name:_______________________________DOB:_________Mailing Address: ____________________________

Best Contact Phone Number:__________________Relationship to Patient: _______________________________

Employer Name:______________________________Employer Phone Number: ___________________________

CONSENT TO RECEIVE VOICEMAIL, TEXT AND/OR EMAIL MESSAGES

Patients in our practice may be contacted via voicemail, email and/or text messaging as a reminder of appointment(s), and/or to provide healthcare reminders/information. By initialing, I consent to receiving appointment reminders, patient portal information, and other healthcare communications and/or information from High Country Community Health. I understand that this consent will apply to all future communication unless I request a change in writing. **Initial** __________

I authorize to receive voice and/or text messages to the phone numbers provided below. I authorize to receive email messages at the email provided below.

Home Phone: ____________________________ ☐ Brief message (includes no health information) ☐ Extended message (Detailed)

Cell Phone: ______________________________ ☐ Brief message (includes no health information) ☐ Extended message (Detailed)

Email Address: ___________________________ ☐ Brief message (includes no health information) ☐ Extended message (Detailed)

Revoke or Decline Use Only: I hereby decline my consent to receive any future appointment reminders, patient portal information, and/or healthcare information via ☐ voicemail ☐ text messaging and/or ☐ email.

I GIVE HIGH COUNTRY COMMUNITY HEALTH PERMISSION TO SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PEOPLE IF REQUESTED:

Name: ___________________________ Contact: _______________________ Relationship: ____________________

Name: ___________________________ Contact: _______________________ Relationship: ____________________

Name: ___________________________ Contact: _______________________ Relationship: ____________________

Patient or Guardian's Signature: __________________________________ Date: ___________________

Patient Name: ________________________________ Date of Birth: __________

Consent for Healthcare and Release of Personal Health Information:

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care, and/or Behavioral Health) from the providers and staff of High Country Community Health (HCCH). I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work, (including HIV testing), immunizations, and referrals. I am aware that neither the practice of medicine, dental treatment, nor the delivery of mental/behavioral health treatment is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that HCCH employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between HCCH providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment, and healthcare operations. I understand that my medical information could include medical history or information regarding diagnosis and treatment for communicable disease (such as sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can op-out by visiting www.highcountrycommunityhealth.com and completing the Opt-out form. I understand that North Carolina Statutes Section 90-21.5 protects a minor's rights to receive services relating to sexually transmitted disease, pregnancy, drug abuse and emotionally disturbances without parental consent. I understand that according to NC General Statutes 90-21.4 medical providers are not required to notify me about services provided in these areas unless the situation indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. This consent is renewable annually. I may withdraw authorization for services at any time. **Initial** ____

HIPAA Notice of Privacy Practice Acknowledgement:

We are required, upon request, by law to provide you with our HIPAA Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows: by visiting www.highcountrycommunityhealth.com, or by requesting one at any HCCH location. **Initial** _______

Financial Responsibility and Assignment of Insurance Benefits:

I understand that for my convenience HCCH accepts Cash, Checks (no starter checks), Visa, MasterCard, Discover or Care Credit (dental only). I also understand that HCCH files with Medicaid, Medicare and many private insurance companies. I authorize my insurance benefits to be paid to HCCH. It is my responsibility to check that HCCH is in network with my private/dental insurance prior to my first appointment. Co-pays are due and collected at the time the services are rendered. If for any reason my insurance company does not pay its estimated portion the balance will be my responsibility. I agree to promptly pay for any balance not covered be insurance. I understand that there may be additional charges including, but not limited to, health screening, behavioral health services, nutritional services, dental services, vaccines and injections. Labs sent to outside laboratories (e.g., LabCorp, Wake Forest Labs or Quest) will be billed separately and are not a part of HCCH. A separate bill from the lab company will arrive by mail. A copy of my Driver's License/Photo ID is required for every patient along with a copy of your Medical/Dental Insurance Card or Medicaid Card. High Country Community Health also providers a Sliding Fee Scale payment option for all our patient. Proof of income and household size are required to qualify. **Initial** _____________

I understand that if I am 18 years of age or older, I may consent for health services; otherwise my parent or legal guardian will need to consent for services.

________________________________ __________________

Signature of Patient or Authorized Person Date

________________________________ __________________

Insured Party of Financial Guarantor (if different from above) Date

Patient Name:______________________________ DOB:_____________________ Today's Date:________________________

Patient Health Screenings for Depression and Anxiety (PHQ-9 and GAD-7):

Your health and wellness are our goals at High Country Community Health. In order to provide you with the best possible care, it is important that we have all information about your physical and mental health as well as your lifestyle habits. Whole person care means not only that the mind and body are connected, but that they affect all aspects of your health. Please complete the Patient Health Screenings below so that your medical provider is better able to help you reach and maintain your best level of health.

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

---

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

Developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute, 1999.

Initials: __________ DOB: __________

AUDIT

In reference to the last 12 months, please circle your response.

1. **How often do you have a drink containing alcohol?**
   (0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
   (0) 1-2 (1) 3-4 (2) 5-6 (3) 7-9 (4) 10 or more

3. **How often do you have six or more drinks on one occasion?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. **How often during the last year have you found that you were unable to stop drinking once you started?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. **How often during the last year have you failed to do what was normally expected of you because of drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. **How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. **How often during the last year have you felt guilt or remorse after drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. **How often during the last year have you been unable to remember what happened the night before because of drinking?**
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. **Have you or someone else been injured as the result of your drinking?**
   (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. **Has a friend, relative, doctor or other health worker been concerned about your drinking or suggested you cut down?**
    (0) No (2) Yes, but not in the last year (4) Yes, during the last year

Total Score (add your circled responses): _______________

DAST-10

In reference to the last 12 months, please circle your response.

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you had “blackouts” or “flashbacks” as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medial problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?

1.Yes	No
2.Yes	No
3.Yes	No
4.Yes	No
5.Yes	No
6.Yes	No
7.Yes	No
8.Yes	No
9.Yes	No
10.Yes	No

Total Score (add your circled YES responses): _______________

ADULT MEDICAL HISTORY FORM

Patient Name: _________________________________ Date of Birth: _______________________ Today's Date: _____________

PLEASE LIST YOUR OTHER HEALTH CARE PROVIDERS: If you need more space, write on the back of this form.

Specialty	Doctor's Name	Date of last visit
Primary Care Provider (PCP)		
Eye Doctor		
Dentist		
Other:		

MEDICATIONS: Please list all medications you are currently taking including birth control, vitamins, supplements, and over the counter medications. If you need more space, write on the back of this form. *Please bring all medications bottles to each appointment*

Drug	Dosage	Frequency

MEDICAL/DENTAL HISTORY: Please check all current AND previous illnesses/conditions for your medical and/or dental history.

- o Blood Disease
- o Breast Disease
- o Cancer
- o Diabetes/Thyroid Problems
- o Female Problems
- o Head, Eyes, Ear, Nose, Throat
- o Hearing Loss
- o Heart Disease
- o High Blood Pressure
- o HIV
- o Kidney Problems
- o Learning Disability
- o Lung Problems (COPD, Asthma)
- o Male Problems
- o Mental Illness
- o Osteoporosis
- o Rheumatology/Arthritis
- o Skin Problems
- o Stroke/Seizures
- o Stomach Problems
- o STI/STD
- o Vision Problems
- o Other: _______________
- o Other: _______________
- o Other: _______________
- o Bad Breath
- o Bleeding Gums
- o Clicking/Popping Jaw
- o Grinding Teeth
- o Loose Teeth/Broken Fillings
- o Periodontal Treatment
- o Sensitivity to cold, hot, sweets
- o Sensitivity when biting
- o Sores or growth in your mouth
- o Other: ______________________

ALLERGIES: Please list any food or drugs that you are allergic to. If you need more space, write on the back of this form.

Food or Drug	Reaction	Mild/Moderate/Severe

GYN/OB History Women Only:

Is there a possibility of pregnancy? **YES or NO** Expected delivery date: ________ Are you nursing? **YES or NO**

Are you taking Birth Control pills (Antibiotics may alter the effectiveness)? **YES or NO**

Date of last period: __________ Age when period started: __________ Age when period stopped (Menopause): __________

Date of last Pap Test: __________ Result of last Pap Test: **NORMAL or ABNORMAL** Treatment: __________________

Date of last Mammogram: _________ Result of last Mammogram: **NORMAL or ABNORMAL** Treatment: ___________

# of Pregnancies: __________ #of Miscarriages: __________ # of Abortions: __________ # of Living Children: __________

1)Has a physician (Medical Doctor) recommended taking antibiotics prior to every dental visit (premed)? YES or NO

2)Have you ever taken Bisphosphonates Fosamax? YES or NO

3)Do you use controlled substances (example Percocet, Hydrocodone, Tramadol)? YES or NO

Initials: __________ DOB: __________

PAST OPERATIONS (in the last 2 years) or HOSPITALIZATIONS (in the last 6 months):

Type of surgery/reason for hospitalization	Name of Doctor or facility	Date

FAMILY HISTORY: Please check family members with past/present medical history.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children	Non-Contributory
Bleeding Problems							
Bone Disease							
Cancer							
Diabetes/Thyroid Problems							
Glaucoma							
High Blood Pressure							
Kidney Problems							
Mental Illness/Depression							
Osteoporosis							
Stroke/Seizures							
Substance Abuse/Addiction							

SOCIAL HISTORY: Please check any health habits.

Activity	How often?	How much?	Type?
Tobacco			
Alcohol			
Physical Activity			
Caffeine			
Substance Use			

REVIEW OF SYSTEMS (ROS): Please check any symptoms you currently have.

- NONE
- Fever/Chills
- Fatigue
- Headache
- Sore throat
- Sinus pain
- Cough
- Shortness of breath
- Jaw pain
- Chest pain
- Palpitations
- Abdominal pain
- Diarrhea
- Nausea/Vomiting
- Rectal bleeding
- Rapid weight loss/gain
- Difficulty urinating
- Burning with urination
- Back/neck pain
- Swelling of face/hands/feet
- Joint pain
- Anxiety/Depression
- Suicidal thoughts
- Other: ______________________
- Other: ______________________
- Other: ______________________

DATE OF MOST RECENT VACCINES:

Flu: ___________ Tetanus: ___________ Pneumonia: ___________ Shingles: ___________ COVID-19: ___________ Other: __________

PREVENTATIVE MEDICINE: Please check and update any of the following that apply.

	Date (Mo/Yr)	**Normal Result**	**Abnormal Result**	**Where Completed?**
Colonoscopy/Colorectal Cancer Screening				
Prostate Cancer Screening				
Bone Density				
HIV Screening				
Hep C Screening				

PRAPARE FORM

Money & Resources

What is your current housing situation?

- ☐ I have housing.
- ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park).
- ☐ I choose not to answer this question

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

What is the highest level of school that you have finished?

- ☐ Less than a high school degree
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question.

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part-time or temporary work
- ☐ Full-time work
- ☐ I choose not to answer this question.
- ☐ Otherwise unemployed, but not seeking work (ex. Student, retired, disabled, unpaid primary care giver)

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ I do not have problems meeting my needs
- ☐ Child care
- ☐ Medicine or any health care (medical, dental, mental or vision)
- ☐ I choose not to answer this question.
- ☐ Phone
- ☐ Other (please write in notes)

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications.
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living.
- ☐ No
- ☐ I choose not to answer this question.

Social & Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: talking to friend on the phone, visiting friends or family, going to church or club meetings)

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question.

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.

- ☐ Not at all
- ☐ Quite a bit
- ☐ Very much
- ☐ A little bit
- ☐ I choose not to answer this question.
- ☐ Somewhat

Additional Questions

In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correctional facility?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

Are you a refugee?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question.

What country are you from?

- ☐ United States
- ☐ Country Other than the United States (please write in notes)
- ☐ I choose not to answer this question.

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question.

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year.
- ☐ I choose not to answer this question.

Questions that will help the Patient Resource Specialist (PRS) care team to assist you with additional needs. If your answer is yes to the below statements, please check the applicable box.

- ☐ I would like to register to vote.
- ☐ I need help filling my taxes.
- ☐ I need information about end of life decisions.
- ☐ If I were admitted to the hospital, I would need help alerting a family member about pets/issues to take care of at home.
- ☐ I/my family need a winter jacket.

Application for Sliding Fee Scale

An application for each household is required every 12 months.

Date: ________________

Patient Name: ____

Please include all of the following sources of income for the last 12 months for each household member. (Household members who currently live together and share income and expenses.)

All Employment

SSI Disability

Work First (TANF)

Veteran Benefit

Alimony Payments

Retirement Income

Social Security Income

Unemployment

Child Support Payments

Any other Income

Name	Date Of Birth	Relationship To Patient	Income Source	Gross Income Before Taxes	Frequency Paid	Front Desk Calculated Annual Amount	Front Desk Source of Verification

I certify that the income information given to High Country community Health from me is correct and accurate.

Please initial the following:

_______ Sliding Fee Scale eligibility is effective for all services provided today until 12 months from today. I understand I will need to reapply for the sliding fee scale 12 months from today.

______ I agree to notify High Country Community Health immediately if my contact or income information changes.

High Country Community Health will not refuse care based on inability to pay.

Responsible Party Signature: ________________________________ Date: ________________

Staff Signature: ____ Date: _________________

STAFF USE ONLY					
	Household Size:	Annual Gross Income:			
Verified Income:	0 – 100% FPL	101 – 125% FPL	126 – 150% FPL	151 – 200% FPL	>201% FPL

**Staff: Please include income calculations in the margin of this form or on separate sheet of paper and scan it into the patients records with all income verification. **

Household Income (If completing SFS Application you may skip)

In order for our clinic to receive federal financial support for patients of low income, we ask that you complete the following annual **household** income form. No individual information is provided to the federal government.

Based on your family size, please circle the income level of your household. The dollar amounts are maximums. For example, if you have a family size of two and make $20,441 annually (i.e., one dollar more than the first column amount), then round up and circle $25,550. Please ask our staff for assistance if needed.

Family Size:	Annual Household income:				
1	$15,060	$18,825	$22,590	$30,120	>$30,120
2	$20,440	$25,550	$30,660	$40,880	>$40,880
3	$25,820	$32,275	$38,730	$51,640	>$51,640
4	$31,200	$39,000	$46,800	$62,400	>$62,400
5	$36,580	$45,725	$54,870	$73,160	>$73,160
6	$41,960	$52,450	$62,940	$83,920	>$83,920
7	$47,340	$59,175	$71,010	$94,680	>$94,680
8	$52,720	$65,900	$79,080	$105,440	>$105,440

For each additional household member, add $5,380.

Patient Name: ____

Patient Signature: ____ Date: _________

Staff Signature: ____ Date: _________