FIRST care CLINIC

PATIENT INFORMATION SHEET

Patient Name: _____ Date of Birth: _____

Gender: Male / Female / Other: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ (required for patient portal access)
If you don't want to receive patient portal registration information via email, please check here: ☐

Employer: _____ Occupation: _____

# of People in Household: _____ Total Household Income: _____

Marital Status: _____ Religion: _____

Primary Doctor: _____ Primary Dentist: _____

Advanced Directive: Yes ☐ No ☐ Are you a veteran? Yes ☐ No ☐

Do you have health insurance? Yes ☐ No ☐ Plan: _____ Policy #: _____

Do you have dental insurance? Yes ☐ No ☐ Plan: _____ Policy #: _____

Race/Ethnicity:
- American Indian/Native Alaskan ☐
- Asian ☐
- Black/African American ☐
- Hispanic or Latino (All Races) ☐
- Pacific Islander ☐
- White (Not Hispanic or Latino) ☐
- Unknown/Other ☐

Preferred Language:
- English ☐
- Spanish ☐
- Other: _____
- Interpreter Needed ☐

Health Insurance Policy Holder Information (If different from patient)

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Dental Insurance Policy Holder Information (If different from patient)

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Person Responsible to Pay the Bill – Guarantor (If different from patient)

Name: _____ Date of Birth: _____ Relationship to Patient: _____

Address: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Work #: _____

FIRST care CLINIC

HEALTH INFORMATION

Name: _____ Date of Birth: _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Check Any Illness or Conditions You Have Had

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Penicillin Allergy
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Do you have artificial joints or valves? ☐ Yes ☐ No

If yes, what joint? _____ When were they received? _____

Do you have a history of alcohol, tobacco, or recreational drug use/abuse? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever taken any meds for Osteoporosis or weak bones? ☐ Yes ☐ No

If yes, please explain: _____

By mouth or IV? _____ Last time taken? _____

Do you ever take blood thinners? ☐ Yes ☐ No

If yes, please explain: _____

Are you pregnant, nursing, or on birth control? ☐ Yes ☐ No

If yes, please explain: _____

* If pregnant, what is your due date? _____

* If taking birth control, please be aware that any prescribed antibiotics could offset its effectiveness

Do you have any known Drug/Medication Allergies? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

If you checked "cancer" above, please explain the following:

Type: _____ When you were diagnosed: _____

FIRST care CLINIC

What type of treatment did you receive? _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes please explain: _____

What pharmacy do you use? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient's Signature: _____ **Date**: _____

FIRST care CLINIC

PATIENT RIGHTS & RESPONSIBILITIES

PATIENT NAME: _____ **DATE OF BIRTH:** _____

YOUR RIGHTS AS A PATIENT

1. You have the right to considerate and respectful care regardless of race, color, age, gender, gender identity, sexual orientation, religion, national origin, language spoken (including if you don't speak or understand the English language), handicap status, or the existence of Advance Directive.
2. You have the right to a safe and private environment for patient care. This includes both personal privacy and informational confidentiality. Case discussion, consultation, examination, and treatment are to be carried out with discretion.
3. You have the right to information regarding your medical care and treatment. First Care Clinic will rely on the provider and/or nurse to keep you informed concerning your progress, diagnosis and treatment modality. You, and when necessary, your surrogate decision-maker, should participate in decisions relating to your care.
4. You have the right to receive from your provider the information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. You have the right to know the name of the person responsible for the procedure and/or treatment.
5. You and your surrogate decision-maker have the right within legal boundaries, to refuse treatment and be informed of the medical consequences of your action.
6. You have the right to request information and assistance to prepare Advance Directives consistent with Kansas Law.
7. You have the right to expect that within its capacity, First Care Clinic will make reasonable response to your request for services. The Health Center will provide evaluation services, and/or referral as indicated by the urgency of the case.
8. You have the right to consent or refuse to participate in experimental, investigational, educational, or research activity related to your care.
9. You have the right to have explained to you the First Care Clinic rules, regulations, policies, procedures, and charges that relate to your care.
10. You have the right to express concerns, complaints, or care-related concerns.

In many situations, First Care Clinic will not release patient-identifiable medical information outside this institution without your written authorization. You may revoke your authorization at any time by notifying the clinic in writing. However, in circumstances defined by law, health care providers are required to report information to the appropriate persons. For example, it must be reported when there are suspicions of child abuse or neglect, or threat of harm to self or others.

YOUR RESPONSIBILITIES AS A PATIENT

1. You are responsible to provide accurate and complete information about your present and past health problems and illnesses, hospitalizations, medications, and your response to current treatment.
2. You are responsible to learn about your illness and care, to ask about care alternatives including the risks and benefits of each and to make your preference clear to the health professionals involved in your care.
3. You are responsible to follow the treatment plan recommended by medical personnel attending your care. Your are responsible for the consequences for failure to follow instructions for refusal of treatment or for failure to follow recommendations for your continuing care when referred from First Care Clinic to a specialty medical service provider.
4. You are responsible to follow First Care Clinic rules and regulations affecting patient care and personal conduct.
5. You are responsible to be respectful and considerate of the rights of other patients and First Care Clinic's personnel and property.
6. You are responsible to express concerns, complaints, or care-related conflicts to your provider or a member of First Care Clinic staff.
7. The undersigned guarantees payment in accordance with clinic payment policies.

I understand the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all the conditions for treatment at First Care Clinic as described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions of Treatment on the patient's behalf.

_____ _____

Patient or Parent/Guardian Signature Date

FIRST CARE CLINIC POLICIES

Patient Name: _____ Date of Birth: _____

Financial Responsibility Policy

The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment of our fees in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf (if applicable). However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim or if you or your physician elect to continue past your approved period, you will be responsible for your balance in full.

I authorize my insurer to pay any benefits directly to First Care Clinic the full and entire amount of bill incurred by me or the above named patient.

Co-Pay Policy

Some health insurance carriers require a co-pay for services rendered. It is expected and appreciated at the time of service.

Cancellation / No Show Policy

As a patient of First Care Clinic, I understand that it is very important to keep my scheduled appointments and I understand the following:

- I am urged to call within 24 hours prior to canceling a medical or dental appointment.
- I am required to confirm my dental appointments by phone or in person 24 hours prior to my appointment. Failure to do so will result in the appointment being counted as a no-show.
- If I have 3 (medical or dental) no-shows in a 12 month period, I will be placed on same-day status for a period of 6 months.
- If I arrive 10 minutes or more past my scheduled appointment time, I may be rescheduled and the appointment will be counted as a no-show.
- New patients who do not confirm or show for their dental appointment will be unable to schedule another appointment until 6 months after the original appointment.

I agree that I have read the above policies regarding my responsibility to First Care Clinic for providing medical/dental services to me or the above named patient.

_____ _____

Patient/Guarantor Signature Date

Consent for Treatment

I hereby authorize First Care Clinic, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

_____ _____

Patient/Guarantor Signature Date

FIRST care CLINIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I acknowledge that I have received a copy of First Care Clinic's Notice of Privacy Practices effective September 17, 2013.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION

I give First Care Clinic permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services.

If you decline to give such permission, leave the following blank.

1) _____ Relationship _____ Phone # _____

2) _____ Relationship _____ Phone # _____

3) _____ Relationship _____ Phone # _____

4) _____ Relationship _____ Phone # _____

5) _____ Relationship _____ Phone # _____

6) _____ Relationship _____ Phone # _____

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

Copy to be maintained in Patient's health record.

FIRST care CLINIC

Patient Medication List

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Patient Name: _____ Date of Birth: _____

Prescriptions	
Name of Medicine	Dose
Over-the-counter medications, herbal remedies, vitamins	

FIRST care CLINIC

HOUSEHOLD ASSESSMENT INFORMATION

Patient Name: _____ Date of Birth: _____

I understand that by filling out the information below, I will be eligible to participate in the Sliding Fee Scale Program subject to income guidelines. I agree to pay the full and entire amount for treatment given to me or to the above-named patient as determined by the Sliding Fee Scale Program. I also understand that I will be considered a "full fee" patient after the first visit and for every visit thereafter until proof of income is provided.

Patient/Guardian Signature: _____ Date: _____

HOUSEHOLD INFORMTATION

Please list all members of your household, including yourself

Name	Relationship	Date of Birth	Age	Sex	Annual Income

FOR OFFICE USE ONLY

IDENTIFICATION / ADDRESS:
Driver's License, Employment ID, Birth Certificate, Social Security Card, Utility Bill, Cable Bill — YES ☐ NO ☐

INCOME
Prior Year Tax Return, 2 Most Recent Pay Stubs, Unemployment Statement, Disability Statement, Documentation of Government Assistance, Child Support/Alimony, Statement of Assistance — YES ☐ NO ☐

Verified By: _____ Slide: A B C Full Fee

FIRST care CLINIC

PATIENT NOTIFICATION ACKNOWLEDGEMENT AND CONSENT FORM

_____ **(Patient initials) Consent to Voice Message, Email or Text Message Usage for Appointment Reminders and Other General Health Information Notifications*.** By initialing this paragraph, I consent and acknowledge that I understand that I may be contacted via telephone voice message, email and/or text messaging for patient appointment reminders and/or to receive general health information notifications from First Care Clinic, Inc ("FCC"). Appointment reminders may include information such as, patient name, appointment time and date, steps for rescheduling an appointment, a generic reminder to schedule an appointment for a preventative care service (e.g. annual physical, flu shot) and/or comparable information. Appointment reminders shall not include details related to health care services to be provided. General health information notifications may include information such as, or equivalent to, announcements for health fairs, flu shot clinics, sports physical days, health screenings or other special events sponsored by FCC. I hereby consent that I wish to receive such messaging from FCC for the types of communications stated in the previous sentences by voice message to the telephone number identified below, by text message to the cell phone identified below and/or by email communication to the email address identified below. I understand that this request to receive voice messages, emails and text messages will apply to all future appointment reminders and general health information notifications unless I request a change and I specifically revoke my consent in writing (see below).

The telephone number that I authorize to receive voice messages for appointment reminders and general health information notifications from FCC is _____.

The cell phone number that I authorize to receive text messages for appointment reminders and general health information notifications from FCC is _____.

The email address that I authorize to receive email messages for appointment reminders and general health information notifications from FCC is _____.

Patient Name: _____Date of Birth: _____

Patient/Patient Representative Signature: _____

Date: _____

Time: _____

First Care Clinic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your cell phone carrier for details and pricing as needed).

Revocation for future voice message/text message/email communications

_____ **(Patient initials)** I hereby revoke my request to receive any and all future appointment reminders and general health reminders/information via voice message, text message and/or email.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

OP 1065149.4