BHC **BENEVOLENCE HEALTH CENTERS**

Caring for the Quality Health Needs of our Community

Patient Registration/Demographic Update			
First Name:	Last Name:	MI:	Date of Birth: / /
Address:	City:	State:	Zip:
Home Phone #:	Work Phone #:	Cell Phone #:	
Other Name(s) Used:	E-mail Address:		

Gender Identity:	Sexual Orientation:	Marital Status:	Race:
☐ Female	☐ Heterosexual	☐ Married	☐ American Indian or Alaskan
☐ Male	☐ Homosexual	☐ Single	☐ Native Asian
☐ Transgender (M to F)	☐ Bisexual	☐ Divorced	☐ Black or African American
☐ Transgender (F to M)	☐ Other: _____	☐ Separated	☐ Native Hawaiian or other Pacific Islander
☐ Will not disclose	☐ Do not know	☐ Widowed	☐ White
	☐ Will not disclose	☐ Life Partner	☐ Other: _____

Ethnicity:	Preferred method of contact:	Preferred Language:	Drivers License #:
☐ Hispanic	☐ Mail	☐ English	SS#:
☐ Non-Hispanic	☐ Home Phone	☐ Spanish	
	☐ Cell Phone	☐ Other:_____	
	☐ Email		

Name of Previous Primary Care Provider:	Previous Primary Care Provider #:

Responsible Party (Guarantor/Parent if Patient is a minor) ☐ Self			
First Name:	Last Name:	MI:	Date of Birth:
Address:	City	State:	Zip:
Primary Phone #:	Home Phone #:	Work Phone #:	Cell Phone #:

Emergency Contact (for minor, Must be Parent or Legal Guardian with paperwork)			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone #:	Work Phone	Cell Phone	Relationship to Patient:

Insurance Information		
1. Primary Insurance:	Subscriber ID #:	Group #:
Responsible Person:	Relationship to patient:	
2. Secondary Insurance:	Subscriber ID #:	Group #:
Responsible Person:	Relationship to patient:	

Advanced Directive:	
Do you have an Advanced Directive? (circle one) YES / NO if YES, must provide a copy	Would you like information regarding Advanced Directives? YES / NO

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax
Interpretive Service Needs:	
Do you require Interpretive Services? YES / NO What language?	

CONSENT FOR TREATMENT:

I_____(print name of patient) do hereby consent to and authorize the performance of all medical and/or dental testing, treatments, and/or surgeries, deemed advisable by the physicians and/or staff of the Benevolence Health Centers (BHC) to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical and/or dental services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Benevolence Health Centers (BHC) to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Responsible Party/Parent of Minor: _____

Printed Name of Patient/Responsible Party: _____

Relationship to Patient: _____

Date Signed: _____

ASSIGNMENT OF BENEFITS:

I _____(print name of patient) hereby assign all medical, dental and/or surgical benefits to include major medical and/or dental benefits to which I am entitled, private insurance, and any other health plan to the physician and/or facility on record. I understand that my dental insurance carrier may pay less than the actual dental bill of services; I agree to be responsible for payment of all services rendered in my behalf or my dependents. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for ALL charges whether or not paid by my insurance. I hereby authorize said assignee and/or Benevolence Health Centers (BHC) to release all information necessary to secure payment.

Signature of Patient/Responsible Party/Parent of Minor: _____

Printed Name of Patient/Responsible Party: _____

Relationship to Patient: _____

Date Signed: _____

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, and Healthcare Operations (164.508(a))

I _____(print patients name) understand that as part of my health, Benevolence Health Centers originates and maintains health record describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care of treatment.
I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who may contribute to my health care.
- A secure means of applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing the quality and reviewing the competence of healthcare professionals.

I may request a copy of the Notice of Privacy Practices that provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Benevolence Health Centers notice prior to signing this authorization. I authorize the disclosure of my Protected Health information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506 (a))

I understand that:

- I have the right to review Benevolence Health Centers Notice of Information practices prior to signing this consent
- Benevolence Health Center reserve the right to change the notice and practices and that prior to implementation will mail copy of any revised notices to the address I have provided, if I have requested.
- I have the right to object to the use of my Protected Health Information for directory purpose
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Benevolence Health Centers is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Benevolence Health Centers has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____

Date: _____/_____/_____

DENTAL HISTORY

Dental History and Information:		
Are you interested in any of following dental appointment: [ ] Examination [ ] Emergency [ ] Consult		
Are you happy with the appearance of your teeth?	Yes	No
Do you get dental examinations on routine base? Last dental exam date: / / Name & phone number of the previous dentist (optional):	Yes	No
Do you think you have an active decay or gum disease	Yes	No
Do you brush and floss frequently? Discuss	Yes	No
Do your gums ever bleed?	Yes	No
Do you have clicking, popping or discomfort in the jaw joint?	Yes	No
Do you grind your teeth?	Yes	No
Have your past experience in dental office always been positive?	Yes	No
Do you want to talk to the dentist privately?	Yes	No
Are you under a Physician's care? Name of your Physician: Phone #: What are you being treated for:	Yes	No

Patients Acknowledgement of Receipt of Dental Materials Sheet

I, _____ (print patient name), acknowledge that I was provided with a copy of the Dental Materials Fact Sheet on written date below.

Patient printed name: _____

Patient Signature: _____

Or

Legal Guardian/Parent of minor printed name: _____

Legal Guardia/Parent Signature: _____

Date: _____/_____ /_____

Medical History

Medications – List all medications you take, prescription and non-prescription, and the dosage	
☐ I do not take any medications	
Medication Name	Dosage

Allergies to Medication and/or Food – List all known allergies (drugs/medications, food, animals, etc.)	
☐ No Known Allergies	

Medical History – Check if you have ever experienced the following conditions, and year of onset.			
Condition	Year	Condition	Year
☐None		☐ Gallbladder Disease	
☐Allergies: _____		☐ GERD (Reflux)	
☐Anemia		☐Hepatitis C	
☐Anxiety		☐High Cholesterol	
☐Arthritis		☐ High Blood Pressure	
☐Asthma		☐Liver Disease	
☐Blood Clots		☐Migraine Headaches	
☐Cancer		☐Myocardial Infarction (Heart Attack)	
Type of Cancer: _____		☐Osteoarthritis	
☐Coronary Artery Disease		☐Osteoporosis	
☐Depression		☐Peptic Ulcer Disease	
☐Diabetes Type:_____		☐Renal Disease	
		☐Seizure Disorder	
☐Other:_____		☐Thyroid Disease	
☐Other:_____		☐HIV/Human Immunodeficiency Virus	
		☐AIDS/Acquired Immune Deficiency Disease Disorder	

Surgical History – Check if you have received the following procedures, and year performed.			
Please list all Surgeries you have had:	Year	Please list all Surgeries you have had:	Year

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ Physical Exam		☐ Tuberculosis Test	
☐Gynecological Exam		☐Pulmonary Function Test	
☐Pap smear		☐ Lipid (cholesterol) Panel	
☐Mammogram		☐ Tetanus Vaccine	
☐DEXA Scan		☐Influenza Vaccine	
☐ Colon Cancer Screen		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐Depression Screen	
☐Foot Exam		☐Sexually Transmitted Disease Screen	

Family History –If any family member(s) has had any of the following conditions, please check box:					
☐Adopted (unknown family history)					
Disease:	Mother	Father	Brother	Sister	Other (list who):
☐ Asthma					
☐ Heart Disease					
☐ Cancer (please list):					
☐ Stroke					
☐ Mental Illness					
☐ Diabetes					
☐ High Blood Pressure					
☐ Other (please list)					

Social History: ☐ Decline to Share Information Below			
Occupation:		Last Level of Education:	
Veteran: ☐ Yes ☐No Immigrant: ☐ Yes ☐No		Homeless: ☐Yes ☐No Public Housing/Shelter: ☐Yes ☐No	
Do you have children? Yes No	How many?	# of Females:	# of Males:
Tobacco Use ☐No	☐Daily ☐Weekly ☐Less ☐Former/Year quit:	☐Chewing ☐Pipe ☐Cigar ☐Cigarettes ☐Smokeless	
Alcohol Use ☐No	☐Daily ☐Weekly ☐Less ☐Former/Year quit:	☐Beer ☐Wine ☐Liquor ☐Other:	
Caffeine Use ☐No	☐Daily ☐Weekly ☐Less Former/Year quit:	☐Chocolate ☐Coffee ☐Soda ☐Tea ☐Tablets ☐Other:	

Pediatrics Only:					
Patient Reside with:	Primary	☐Mother	☐Father	☐Both Parents	☐Other:
	Secondary	☐Mother	☐Father	☐Other:	
Mother's Occupation			Father's Occupation		
Parents Relationship ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed			Childcare ☐Mother ☐Sibling ☐Father ☐Nanny ☐Grandparent ☐Daycare		
Tobacco Exposure: ☐Yes ☐No Smokers at home: ☐Yes ☐No			Seeing a Dentist? ☐Yes ☐No		

Medications – List all medications you take, prescription and non-prescription, and the dosage	
☐ I do not take any medications	
Medication Name	Dosage