FLORIDA ATLANTIC UNIVERSITY
Christine E. Lynn College of Nursing

NCHA
NORTHWEST COMMUNITY HEALTH ALLIANCE, INC

COMMUNITY HEALTH CENTER | REGISTRATION PACKET

Dear Patient: We are a non-profit clinic that provides low-cost health care on a sliding scale. Visit costs for patients are determined by a sliding fee scale that is calculated based on income and household size. This practice serves all patients regardless of inability to pay. Due to new federal reporting regulations; the following information is now required for each patient. Please note that all information is confidential. We appreciate your cooperation with these new reporting requirements and will need to collect this information on an annual basis.

Today's Date _____

Patient Information

First Name _____ MI: _____ Date of Birth _____

Last Name _____ Sex Assigned at Birth ☐ Male ☐ Female

Address _____ City _____ Zip Code _____

Phone Number _____ Email Address _____

Pharmacy Name/Address _____ SSN _____

Allergies ☐ No ☐ Yes, Explain

_____

Living Arrangements *(Please Check One)*

☐ Shelter *(safe havens, temporary overnight housing, armories)* ☐ Transitional *(center, community, home)* ☐ Other *(hotel, motel, public housing)*	☐ Doubling Up *(living with other people for a temporary period and move often)* ☐ Street *(sidewalk, car, park, doorway, public or abandoned building)*	☐ Permanent Resident *(own, rent, apartment/ room/house)* ☐ Unhoused

Transportation *(Please Check One)*

☐ Car
☐ Bus-line
☐ Walk/bike
☐ Transport van

Patient Information

Insurance Information (Choose One)

- ☐ Self-pay
- ☐ Medicaid (Plan name and member number)
- ☐ Private or Medicare (Plan name and member number)

Ethnic Origin (Please Check One)

Hispanic ☐ Yes ☐ No

Race (Please Check All That Apply)

☐ Caucasian ☐ Asian ☐ Pacific islander ☐ Native Hawaiian
☐ Black or African-American ☐ American Indian/Alaskan Native ☐ Choose Not to-Disclose

Gender Identity

☐ Male ☐ Transgender Male/Female-to-Male ☐ Choose Not to-Disclose
☐ Female ☐ Transgender Female/Male-to-Female ☐ Other

Sexual Orientation

☐ Straight ☐ Bisexual ☐ Don't know
☐ Lesbian or Gay ☐ Choose Not to-Disclose ☐ Other:

Marital Status

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact

Last Name: _____ First Name: _____

Relation to Patient: _____ Phone Number: _____

In case of an emergency, FAU/NCHA Community. Clinics will provide your medical records to a hospital or other medical institution if you are unable to make medical decisions on your own behalf.

If you wish NOT to have your medical records sent on your behalf, Please check this box:

☐ **In case of an emergency, I do not want my medical records sent on my behalf.**

Initial Health History

Current Symptoms

Please check any symptoms you have now, **if none check here ☐ None**

General
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Unexpected weight loss or gain

Blood/Lymph
- ☐ Anemia
- ☐ Swollen Glands

Bones, Joint, Muscles
- ☐ Muscle aches
- ☐ Neck pain
- ☐ Swollen, painfuljoints

Head, Eyes, Nose and Throat
- ☐ Ear pain
- ☐ Eye pain
- ☐ Headaches
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in your ears
- ☐ Sinus problems
- ☐ Sores or irritation in mouth or throat
- ☐ Teeth or gum problems
- ☐ Vision problems

Heart and Circulation
- ☐ Chest pain or pressure
- ☐ Fast or irregular heartbeat
- ☐ Pain in legs with walking
- ☐ Swelling of feet or ankles

Lungs
- ☐ Coughing up blood
- ☐ Shortness of breathatrest
- ☐ Trouble breathing while lying down
- ☐ Unexpected shortness of breath during activity
- ☐ Wheezing

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Extreme worry
- ☐ Trouble sleeping
- ☐ Trouble thinking or concentrating

Nervous System
- ☐ Trouble with walking
- ☐ Trouble with coordination
- ☐ Dizziness
- ☐ Fainting or black-out spells
- ☐ Memory problems ·
- ☐ Numbness
- ☐ Seizures
- ☐ Shaking
- ☐ Speech problems
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Skin
- ☐ Bleeding or bruising from minor injury
- ☐ Changes in hair or nails
- ☐ Changes in moles
- ☐ Dryness
- ☐ Itching
- ☐ Rashes

Stomach and Intestines
- ☐ Abdominal pain
- ☐ Black stools
- ☐ Bloating
- ☐ Blood instool
- ☐ Bowel habit change
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty or pain with swallowing
- ☐ Heartburn or indigestion
- ☐ Nausea

Urination
- ☐ Frequent daytime urination *(more than 6 times/day)*
- ☐ Trouble holding urine or incontinence
- ☐ Pain or burning
- ☐ Trouble starting or stopping urine
- ☐ Waking to urinate more than 1 time/night

Reproductive
Female
- ☐ Bleeding or spotting between periods
- ☐ Heavy or painful periods
- ☐ Irregular periods
- ☐ Vaginal discharge

Male
- ☐ Prostate problems
- ☐ Scrotal painorswelling

Other

_____

_____

_____

_____

_____

_____

Initial Health History

Current and Past Health History:
Please check any symptoms you have now, **if none check here ☐ None**

Bones and Joints	**Now**	**Past**
Arthritis	☐	☐
Fracture or broken bone	☐	☐
Osteoporosis or thinning of the bones	☐	☐

Head, Ears, Eyes, Nose, & Throat	**Now**	**Past**
Cataracts or glaucoma	☐	☐
Other vision problems	☐	☐
Hearing problems	☐	☐

Heart and Circulation	**Now**	**Past**
Anemia	☐	☐
Bleeding problems	☐	☐
Blood clot	☐	☐
Blood transfusion	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Heart murmur	☐	☐
Heart rhythm problems	☐	☐

Kidneys and Bladder	**Now**	**Past**
Genital problems	☐	☐
Kidney failure	☐	☐
Kidney stones	☐	☐
Other-kidney or bladder problems	☐	☐

Lungs	**Now**	**Past**
Asthma	☐	☐
Emphysema, chronic lung disease	☐	☐
Pneumonia	☐	☐

Nervous System and Behavior	**Now**	**Past**
Depression	☐	☐
Head injury, concussion	☐	☐
Other mental problems	☐	☐
Seizures or epilepsy	☐	☐
Stroke	☐	☐

Skin	**Now**	**Past**
Skin disease	☐	☐

Stomach and Intestine	**Now**	**Past**
Gallbladder problems	☐	☐
Hepatitis, other Liver disease	☐	☐
Stomach ulcers	☐	☐

Other	**Now**	**Past**
Abnormal blood sugar	☐	☐
AIDS-or positive HIV test	☐	☐
Cancer	☐	☐
Diabetes (including pregnancy)	☐	☐
Thyroid gland problem or goiter	☐	☐
Transplant (List type):	☐	☐
Tuberculosis or positive TB test	☐	☐
Other (Explain)	☐	☐

Depression Screening

Over the past month, have you felt, down, depressed, or hopeless?

☐ Yes ☐ No

Over the past month, have you felt little interest or pleasure in doing things?

☐ Yes ☐ No

Statement of Present Health

Please check the box that best represents your present health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you take any prescription drugs routinely?

☐ No ☐ Yes

If yes, please explain: _____

Do you take any non-prescription drugs, herbs, or supplementsr outinely? ☐ No ☐ Yes

If yes, please explain: _____

Do you have any medication, food, or environmental allergies? ☐ No ☐ Yes

If yes, please explain: _____

Do you exercise regularly? ☐ No ☐ Yes

If yes, how often: _____

Are you currently experiencing any oral pain? ☐ No ☐ Yes

If yes, please explain: _____

Have you ever been hospitalized? ☐ No ☐ Yes

If yes, please explain: (when/where) _____

Haveyouever had surgery? ☐ No ☐ Yes

If yes, please explain: (when/where) _____

Do you smoke, drink, or use recreational, drugs ☐ No ☐ Yes

If yes, please explain how much /how often of each _____

Date of most recent physical exam/labs _____

Date of most recent tetanus _____

Dateof most recent colonoscopy _____

Date of most recent pap smear _____ Was it ☐ Normal or ☐ Abnormal

Date of most recent TB test _____

Date of most recent mammogram _____

Date of most recent dental visit _____

Family History

Has anyone in your immediate family ever had any of the following?

Please check all that apply.

If none, check here: ☐ None

☐Alcoholism	☐Diabetes	☐HIV/AIDS	☐Stomach/Intestine
☐Anemia	☐Depression	☐ Kidneydisease	☐Stroke
☐Anxiety	☐High blood pressure	☐Lung disease	☐Suicide
☐Cancer	☐Heart disease	☐Migraines	☐Thyroid disease
☐Convulsions	☐Hepatitis	☐Mental disorders	☐Tuberculosis

Gynecologic History *(Men continue to ''Sexual History")*

Do you still menstruate? ☐Yes ☐No if yes, when was last period: If no, please explain:

If you have had a hysterectomy, were your ovaries removed? ☐Yes ☐No ☐ Don't know

How many pregnancies have you had? _____

How many children have you given birth to? _____

Are you currently pregnant or trying to get pregnant? ☐Yes ☐No ☐ Don t know

Sexual History

What is your current method of birth control?

☐ I am not sexually active ☐ Same sex partner ☐No birth control ☐ *(female)* I am post-menopausal

Have you ever had any of the following sexually transmitted diseases?

☐ Chlamydia ☐Syphilis ☐Trichomonas ☐ PID/Pelvic inflammatory disease

☐ Gonorrhea ☐Herpes ☐Genital warts ☐None ☐Don't know

Structured information

Do you have limited access to food? ☐ No ☐ Yes If yes, please explain _____

Occupation ☐Full-time ☐ Part-time ☐Student ☐ Seasonal worker ☐ Migrant worker

Country of origin _____

Limited English ☐No ☐Yes Do you need a translator? ☐No ☐Yes ☐N/A

How did you hear about FAU clinic? ☐ Outreach ☐ Internet ☐ Insurance ☐Family/friend ☐ Other

Pronouns

☐ he/him/his/his/himself

☐ she/her/her/hers/herself

☐ they/them/their/theirs/themselves

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Print Name of Patient (or Authorized Personal Representative)	Date
Signature of Patient (or Authorized Personal Representative)	Authority of Personal Representative *(e.g., parent, legal guardian, health care surrogate)*

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility.

The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: physicians, residents, fellows, healthcare students, physician assistants, advanced registered nurse practitioners, perfusionists, nurses, pharmacists, and technicians, who will at all times be under the exclusive supervision and control of FAU. I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Print Name of Patient (or Authorized Personal Representative)	Date
Signature of Patient (or Authorized Personal Representative)	Authority of Personal Representative *(e.g., parent, legal guardian, health care surrogate)*

AGREEMENT TO MEDIATE

In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Print Name of Patient (or Authorized Personal Representative)	Date
Signature of Patient (or Authorized Personal Representative)	Authority of Personal Representative *(e.g., parent, legal guardian, health care surrogate)*

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ADULT CONSENT FOR TREATMENT

Name _____ DOB _____

I, _____ authorize and do voluntarily consent to and authorize the FAU Christine E. Lynn College of Nursing Community Health Center to provide preventive, diagnostic, and therapeutic procedures and treatment. These procedures and treatment are considered necessary or advisable in the judgment of the attending Health Care Provider, his/her assistants or designees.

I understand that no guarantees have been made to me as to the results of the treatment or examinations. I understand the consent form and accept its contents.

_____	_____	_____
Signature	Relationship of Representative	Date

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PEDIATRIC CONSENT FOR TREATMENT

Name _____ DOB _____

I, _____ authorize and do voluntarily consent to and authorize the FAU Christine E. Lynn College of Nursing Community Health Center to provide preventive, diagnostic, and therapeutic procedures and treatment. These procedures and treatment are considered necessary or advisable in the judgment of the attending Health Care Provider, his/her assistants or designees.

I understand that no guarantees have been made to me as to the results of the treatment or examinations. I understand the consent form and accept its contents.

_____	_____	_____
Signature	Relationship of Representative	Date

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FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors

Notice to Patients

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____
(Patient signature)

_____
(Patient name, printed legibly)

_____
Date