Ilanka Community Health Center
PATIENT REGISTRATION FORM

OFFICE USE ONLY
MRN #: _____ Account #: _____
Provider: □ Rush □ Iutzi □ Other:_____
Tribal Ben Status: □ Covered □ Non-Covered □ Non-Ben
□ Employee □ Other _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Previous Last Name: _____ Nickname: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

If minor patient, Name of Guarantor / Responsible Party: _____

MAILING ADDRESS _____ **PERMANENT ADDRESS** _____

PHYSICAL ADDRESS _____ _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Email Address: _____ Permanent Home Phone: _____

Phone: _____ **Preferred Contact#**: _____ (cell□)

PATIENT EMPLOYER: (□ minor patient / □ no employer) **Please select a Primary Care Provider:**

Name of Employer: _____
Phone: _____

Dr. Kristel Rush: ( )
Dr. Brian Iutzi: ( )
Bios available, please request at Front Desk

DEMOGRAPHIC INFORMATION

Our federal grant requires us to collect and report on this information, in an effort to provide culturally competent healthcare services. The information is reported on the population as a whole, not by specific individual.

Race:	Ethnic Identity	Primary Language
□ Alaska Native / American Indian Tribe:_____ □ Asian □ Black / African American □ More than one race □ Native Hawaiian/Other Pacific Islander □ Other Race □ White □ Choose Not to Disclose	□ Hispanic / Latino □ Not Hispanic/Latino □ Choose Not to Disclose	□ English □ Other (please identify) _____ Interpreter Required? □ Yes □ No
	Veteran Status *(Have you served in the U.S. Military?)* □ Yes □ No	Annual Income:_____ Would you like to apply for sliding fee? _____

PRIVACY PRACTICES ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review the Notice.

Printed Name: _____ (□ minor) Signature: _____

Date: _____ Relationship to minor patient: _____

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BILLING INFORMATION

Guarantor / Responsible Party □ patient / same as above

Last Name: _____ First Name: _____ Middle: _____

SSN: _____ Date of Birth: _____ Gender: □ Male □ Female

MAILING ADDRESS _____ Home Phone: _____

PHYSICAL ADDRESS _____ Cell Phone: _____

City: _____ Other Phone: _____

State: _____ Zip: _____

Email Address: _____

EMPLOYER: (□ no employer) _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy # _____ Group #: _____

Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Relationship to Patient: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship to Patient: _____

NEXT OF KIN:

Name: _____ Phone: _____

Relationship to Patient: _____

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Please answer the following questions honestly and thoroughly. The answers on this form will help your clinician understand your medical concerns and conditions better. Thank you and welcome to Ilanka.

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

What is the reason for your visit today?

1. _____
2._____

PERSONAL AND FAMILY MEDICAL HISTORY

Please indicate with an (x) for self or family members who had any of the following conditions:

Medical Condition	Self	Mom	Dad	Bro	Sis	Medical Condition	Self	Mom	Dad	Bro	Sis
ADD/ADHD						Hearing Deficiency					
Alcoholism						Hypertension					
Allergies						Irritable Bowel Disease					
Alzheimer's Disease						Learning Disability					
Arthritis Type:						Mental Illness					
Asthma						Migraines					
Blood Disorder						Obesity					
Cancer Type:						Osteoporosis					
Cardiovascular Disease Type:						Peripheral Vascular Disease					
Coronary Artery Disease						Renal Disease					
Depression						Seizure Disorder					
Developmental Delay						Stroke					
Diabetes Type:						Substance Abuse					
Eczema						Thyroid Disorder					
Elevated Lipids						Other:					
Genetic Disease											

ALLERGIES or REACTIONS TO MEDICINES/FOOD/OTHER AGENTS

(use back of page if needed)

Medication/Food	Reaction or Side Effect

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MEDICATIONS *Please list all prescription, non-prescription medicines, vitamins, home remedies, herbs, etc. Use back of page for more space*.

Medication	Dose	Times per day	Date started	Prescribing Physician

OTHER HEALTHCARE PROVIDERS, SPECIALISTS, PT or CHIROPRACTORIC VISITS?
Please list name and dates.

OTHER HEALTHCARE PROVIDERS	DATE	COMMENTS

HOSPITALIZATIONS, ER VISITS OR SURGICAL HISTORY *Please list all with corresponding dates.*

HOSPITALIZATIONS, ER VISITS, OPERATIONS	DATE	COMMENTS

WOMEN'S GYNECOLOGIC HISTORY

# of pregnancies	
# of term deliveries	
# of preterm deliveries	
# of miscarriages, abortions	
# of living children	
Age at 1st period	
Age of menopause	
1st day of last period	
Frequency of periods	
Length of each	

Have you ever had a mammogram?
NO____ YES___Date/location of last _____
What is the date/location of your last pap smear?
DATE_____ LOCATION _____
Have you ever had an abnormal pap smear?
NO_____ YES_____ if so, date_____
Have you ever had a colonoscopy?
NO_____YES_____ DATE_____
May we request your colonoscopy records?
If so, please provide your provider's name:
_____

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SOCIOECONOMICS

Occupation:_____

Education Completed: *(please circle)*

Grade School	**Yes**	**No**
High School	**Yes**	**No**
College	**Yes**	**No**
Graduate School	**Yes**	**No**

Marital Status: *(please circle)*

Single Married Divorced Widowed Engaged

Co-habiting Other_____

Number of children:_____

Who lives at home with you?_____

_____

SEXUALITY (please circle)

Are you sexually active?

Yes No Not currently N/A

If sexually active, do you practice safe sex?

Yes No Not currently N/A

Are you interested in being screened for STDs?

Yes No Not currently N/A

Contraception and Protection

Birth Control method:_____

None needed_____

Have you ever had a sexually transmitted disease?

No____Yes____Type/date_____

Other sexual concerns:_____

_____

As a health center, we are required to collect gender identity and sexual orientation info from our patients. This information is reported to Health Resource Services Administration as a whole, not by specific individual.

Would you like to disclose your sexual orientation: Y N

If Yes, please circle one of the following:

*Lesbian or Gay *Straight (not lesbian or gay)

*Bisexual *Something else

*Don't know

Would you like to disclose your gender identity?

Y N

If yes, please circle one of the following:

*Male *Female

*Transgender Male (Female to Male)

*Transgender Female (Male to Female)

*Other

Definitions:

Sexual Orientation: a person's sexual identity in relation to the gender to which they are attracted.

Gender Identity: a person's perception of having a gender, which may or may not correspond to the gender they were assigned at birth.

Transgender: a person who identifies with or expresses a gender identity that differs from the person's sex at birth.

SAFETY (please circle)

Do you use seatbelts consistently?	Y	N
Are there smoke detectors in the home?	Y	N
Are there carbon monoxide detectors in the home?	Y	N
Have you had any falls in the last year?	Y	N
If so, did the fall result in injury?	Y	N
Are there firearms in the home?	Y	N
If so, are they locked?	Y	N
Is violence a concern for you?	Y	N
Do you feel safe in your current relationship?	Y	N

Do you have any other safety concerns?

_____

_____

COMMUNICATION NEEDS (please circle)

Hard of Hearing	Y	N
Vision Impaired	Y	N

Other:_____

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SUBSTANCES

Tobacco Use: Never _____ Quit date_____
Current Smoker: packs/day_____ #of yrs_____
Vaping/e-cigarette within last 30 days? Y N
Other tobacco: pipe ( ) cigars ( ) snuff ( ) chew ( )

Are you interested in quitting? Yes_____ No_____

Do you drink alcohol? No Yes drinks/week___
Is alcohol use a concern for you or others? Y N

Do you use recreational drugs? Y N
Have you ever used needles? Y N

Caffeine? No___ Yes___ amount___ type___

EXERCISE

Do you exercise regularly? Y N
If yes, hours per week? _____
Type of exercise:_____
Do you follow a diet? Y N
If yes, what type?_____

DEPRESSION

Are you experiencing anxiety? Y N
Would you like to seek help? Y N

Over the last 2 weeks, how often have you been bothered by any of the following problems:

1. *Little interest or pleasure in doing things*
   Not at all Several Days
   More than half the days Nearly every day
2. *Feeling down, depressed of hopeless*
   Not at all Several Days
   More than half the days Nearly every day

COMMENTS:_____
_____
_____

Thank you for completing!

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CONSENT FOR EVALUATION AND TREATMENT:

Ilanka Community Health Center provides comprehensive Primary Care and Behavioral Health services. Since wellness involves body and mind, our providers may involve other healthcare specialists such as Behavioral Health Clinicians, a Care Coordinator or telehealth providers as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure continuity of care. *If you prefer to limit the sharing of information, please inform the Front Desk Staff before your appointment.*

By signing this form, I agree that I have read or had this form read and/or explained to me, that I understand it and that my questions have been answered. I agree to provide accurate information.

Thus, I hereby consent for Ilanka Community Health Center to evaluate and administer treatment for myself and/or child(ren) as set forth above, including any procedures that ICHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally authorized to make such decisions.

Patient Name:_____ Patient DOB: :_____

Signature:_____ Date:_____

Printed Name if Parent/Guardian Signing:_____