Ann Silverman Community Health Clinic

Please Print

TODAY'S DATE: _____/_____/_____

PATIENT'S NAME: _____ AGE: _____

BIRTHDATE: Month_____ Day_____ Year _____ SEX: _____ RACE: _____

PATIENT'S SOCIAL SECURITY #: _____ LANGUAGE: English Spanish Other: _____

HOME PHONE: _____ CELL #: _____ WORK #: _____

STREET ADDRESS: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

Mailing Address or PO Box if different than street address: _____ APT. # _____

CITY: _____ STATE: _____ ZIP: _____

If Patient is a Minor: ***PARENT*/GUARDIAN NAME: _____**

PARENT/GUARDIAN BIRTHDATE: ____/____/_____ PARENT/GUARDIAN SOCIAL SECURITY #: _____

PARENT/GUARDIAN ADDRESS (if different than above): _____

CITY: _____ STATE: _____ ZIP: _____

Emergency Contact Information

NAME: _____ RELATIONSHIP TO YOU: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____

If we cannot reach you, do we have permission to talk to this person regarding your personal health information?

Yes _____ No _____

Please Answer All of the Following:

1. **Do we have permission to leave a message on your voicemail or answering machine regarding your personal health information? Yes _____ No _____**
2. **Do you have any medical or dental insurance? Yes _____ No _____**

   If yes, what is the name of the insurance company: _____
3. **Are you a Veteran? Yes _____ No _____**
4. **Is this visit in any way related to an accident of any kind or an injury on the job? Yes ___ No ___**

   If yes, describe the accident or injury?_____
5. **What pharmacy do you prefer? Name: _____**

   Address: _____City _____ State: _____

   Phone: _____ Fax: _____

Ann Silverman Community Health Clinic

Authorization for Treatment Services

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

1. I, hereby, authorize medical and/or dental treatment by the Ann Silverman Community Health Clinic.
2. I understand that the services I receive may be provided by volunteer physicians, nurses, nurse practitioners, dentists, and dental hygienists and that all healthcare providers are licensed to practice, as required, in Pennsylvania.
3. I agree to follow the recommendations given to me by the healthcare providers and/or staff of the Ann Silverman Community Health Clinic.
4. I will ask questions if I do not understand something.
5. I retain the right to seek treatment elsewhere, at any time, at my own expense.
6. I agree to provide the Ann Silverman Community Health Clinic with all healthcare insurance or financial information, as requested.
7. I will notify the staff of any changes in my living circumstances, financial or insurance status, or any change in my medical or dental condition.
8. I understand that in order to provide quality services it may be necessary for the staff to communicate with and refer to other resources. I understand that I will be asked to provide written consent to the release of certain information. I retain the right to withdraw the consent at anytime by notifying the Ann Silverman Community Health Clinic either verbally or in writing.
9. I understand that I am responsible for all of my personal belongings.
10. I understand that if I have any questions or concerns about this or any other form or any services, I may ask to meet with the Executive Director of the Ann Silverman Community Health Clinic.
11. I understand that, if I am not satisfied with any decisions of the staff, I may appeal the decision to the Clinical Services Committee of the Ann Silverman Community Health Clinic.

If the patient is 18 years old or older:

SIGNATURE OF PATIENT _____ Date: _____

If patient is a minor, under 18 years of age, parents or legal guardian must sign below:

Signature of Parent/Guardian _____

Date: _____

Relationship to patient (mother/father/guardian, etc.): _____

Signature of Witness _____ **Date:** _____

ANN SILVERMAN
COMMUNITY
HEALTH CLINIC
formerly The Free Clinic of Doylestown

HIPPA – Notice of Privacy Practices and
DOYLESTOWN CLINICAL NETWORK (DCN)

The DCN is a database created by the physicians in the Doylestown community who have some category of membership on the Medical Staff of Doylestown Hospital. This database consists of the medical records of the physicians' patients, including yours if you want to participate. The only physicians allowed to access your records are those who are currently treating you. The DCN should enhance the quality of care provided to you, and reduce the risk that you will be prescribed inappropriate or excess medications.

When registered as a patient in the Ann Silverman Community Health Clinic, you are automatically included in the DCN. The Clinic will include your clinical information, such as allergies, medications, problems, results, etc., in the DCN so it will be available to any physician member of the DCN who is treating you, including participating referring physicians and clinicians at any time they are providing you with care, or in the event of an emergency visit.

If you choose not to participate in the DCN, ask our registration staff for the "opt-out" form. Once you have completed and signed the form, your information will not be shared on the DCN. Please tell any of our staff members of your decision to "opt-out" at any time during your visit. Your clinical information will then not be available via the electronic network.

I hereby understand and agree with the sharing of my clinical data for the purpose of my treatment and care in the Doylestown Clinical Network (DCN).

I am aware of the clinic's HIPAA Privacy Practices and that I may have a copy of these Practices if I request them or by accessing them on our website at www.aschealthclinic.org/eligibility.

Please Sign:

_____

PATIENT, or PARENT/GUARDIAN IF PATIENT IS A MINOR OR IS UNABLE TO SIGN

Please print your name, or the patient's name and the name of the parent/guardian if the patient is a minor or is unable to sign:

_____ _____

PRINT NAME OF PATIENT PRINT NAME OF PATIENT'S PARENT OR GUARDIAN

_____/_____/_____

Date

HEALTH HISTORY

YOUR NAME _____ YOUR AGE_____ TODAY'S DATE _____/_____/_____
Month/ Day / Year

	YES	NO
Would you say that you are in good health?	○	◉
When was your last physical exam?		
Are you currently under the care of a physician? If yes, who is your doctor?		
Have there been any changes in your general health within the past year?		
Have you had a recent weight loss or gain?		
Have you ever been hospitalized for any surgical operations or any serious illnesses? If yes, when and for what?		
Do you have any illness that could interfere with your ability to work or take care of your family? If yes, what?		
Do you have or have you ever had any of the following?		
Allergies of any kind? If yes, what allergies?		
High blood pressure?		
Any heart problems?		
Lung problems, asthma or tuberculosis (TB)?		
Stroke?		
Epilepsy or seizures?		
Depression, nervousness, anxiety or other mental health care?		
Thyroid problems?		
Problems with hearing or vision?		
Hepatitis, jaundice, or liver trouble?		
Diabetes, high or low sugar?		
Stomach ulcer or heartburn/GERD?		
Kidney trouble or kidney stones?		
Arthritis, gout or rheumatism?		
Back problems?		
Have you ever required a blood transfusion?		
Cancer, leukemia or HIV?		
Do you use tobacco? If yes, how much & how often?		
Do you use any illegal drugs or prescription painkillers? If yes, what ?		
Do you drink alcohol? If yes, how much & how often?		
WOMEN ONLY		
When was your last gynecological exam?		
When was your last breast exam by a physician?		
Have you ever had a mammogram? If yes, when?		
MEN ONLY		
When was your last testicular or prostate exam?		

PLEASE COMPLETE BOTH SIDES

HEALTH HISTORY

1. Please describe any other problems or concerns that you have about your health.

   _____

   _____

   _____

2. Are you (or should you be) taking any medications, supplements or vitamins on a regular basis? If yes, what medicines?

   _____

   _____

FAMILY HEALTH HISTORY

If any of your blood relatives (your grandfather, grandmother, father, mother, aunt, uncle, son, daughter) have any of the following, please indicate the relationship of this person to you.
High blood pressure?
Any heart problems?
Stroke?
Depression, nervousness, anxiety or other mental health care?
Diabetes, high or low sugar?
Cancer or leukemia?
Problems with alcohol or drugs?

PLEASE COMPLETE BOTH SIDES

Health Behavior Assessment NAME: _____ DATE _____

As part of our health service it is important to review issues that could affect the health of our patients. This information will help us provide you with the best treatment and the highest possible standard of care. We are asking you to complete this questionnaire that asks about your use of alcoholic beverages because alcohol use can affect your health and can interfere with certain medications. Please answer as accurately and as honestly as possible. All information will be treated in strict confidence.

In the following questions, a drink means one (12 ounce) can or bottle of beer, one (5 ounce) glass of wine, one wine cooler, or a mixed drink with 1.5 oz. of hard liquor. Each counts as one drink; a mixed drink with double shots or a martini counts as two drinks.

Each counts as 1 drink:

1. How often do you drink anything containing alcohol?

0 ☐ Never (skip to Ques. #4)
1 ☐ Less than monthly
2 ☐ Monthly
3 ☐ Weekly
4 ☐ 2-3 times a week
5 ☐ 4-6 times a week
6 ☐ Daily

2. How many drinks do you have on a typical day when you are drinking?

0 ☐ 1 drink
1 ☐ 2 drinks
2 ☐ 3 drinks
3 ☐ 4 drinks
4 ☐ 5-6 drinks
5 ☐ 7-9 drinks
7 ☐ 10 or more drinks

3. How often do you have four or more drinks on one occasion?

0 ☐ Never
1 ☐ Less than monthly
2 ☐ Monthly
3 ☐ Weekly
4 ☐ 2-3 times a week
5 ☐ 4-6 times a week
6 ☐ Daily

4. In the last year have you used drugs other than those required for medical reasons?

Yes ☐ No ☐

5. In the last year, have you used prescription or other drugs more than you meant to?

Yes ☐ No ☐

6. Which drug do you use most frequently? _____

Women = 7+, or yes
Men = 8+, or yes