G.A. CARMICHAEL FAMILY HEALTH CENTER

Put Your Family's Health In Our Hands

PATIENT DEMOGRAPHIC FORM

Today's Date: _____ SS #: _____ **DOB:** _____

PATIENT INFORMATION:

Patient's Name: _____
(First Name) (MI) (Last Name)

I preferred to be addressed as / my nickname is: _____ Email address: _____

Sex at Birth: ☐ M ☐ F ☐ Unknown

Mailing Address: _____
(Street Address) (City/State) (Zip Code)

Home Phone: (____) _____ Cell Phone: (____) _____

PATIENT'S EMPLOYER INFORMATION

Employer's Name: _____

Employer's Address: _____
(Street Address) (City/State) (Zip Code)

Employer's Phone (_____) _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

EMERGENCY CONTACT INFORMATION

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: (____) _____

DEMOGRAPHICS: For Purposes of Grant Funding

1) **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic ☐ Unknown

2) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White
☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than One Race ☐ Refuse to Report

3) **Preferred Language:** ☐English ☐Spanish ☐ other: _____

4) **Preferred Notification Method:** ☐ Postal Mail ☐ Phone ☐ Email

5) **Marital Status**: ☐ Single ☐ Married ☐ Divorce ☐Widow ☐ Life Partner ☐Legally Separated ☐ Other

6) **Household Size:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐10 ☐**OTHER**_____

7) **Estimated Household Income:** $_____ ☐**Weekly** ☐**Bi-Weekly** ☐**Monthly** ☐**Annually**

8) **Primary Language:** ☐ **English** ☐ **Spanish** ☐ **Other**_____

9) **Are you a Veteran of the U.S. Armed Forces?** ☐ **Yes** ☐ **No**

10) **Housing Status:** ☐ **Current Resident of Public Housing**
☐ **HOMELESS: ___Doubling up ____Shelter ___Transitional ___Unknown**
☐ **Not Homeless and Not current resident of public housing**

INSURANCE COVERAGE: *(we will need to make a copy of your cards – please provide your cards)*

Is the patient covered by insurance? Yes / No

If No, please ask about our *Sliding Fee Program Discount*. If yes, please complete the following:

Primary Insurance Company: _____ Primary Insurance Holder: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Primary Insurance Holder: _____

Policy Number: _____ Group Number: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH INSURANCE PROVIDER(S) PAYMENT

I, the patient, hereby authorize any holder of medical information about me to release to the State Medicaid fiscal agent, Medicare fiscal intermediary or other insurance carrier any information needed for this or a related claim. I request that payment of authorized health insurance benefits be made on my behalf to *G.A. Carmichael Family Health Center.*

Patient or Guardian Signature _____ Date _____

GUARANTOR INFORMATION

Is the patient a minor? (Under 18) **Yes / No** *(If Yes, please fill out the Guarantor information)*

Is Guarantor information same as above? **Yes / No** (If No, please fill out the Guarantor information)

Guarantor Name: _____
(First Name) (MI) (Last Name)

Social Security Number: _____ Relationship to patient: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

☐ Same as Emergency Contact.

☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

☐ These are the additional persons I give my permission to disclose information about my medical treatment:

Name: _____ Relationship: _____ Phone #: (____) _____

Name: _____ Relationship: _____ Phone #: (____) _____

ALL PATIENTS PLEASE READ

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of *G.A. Carmichael Family Health Center.* _____ (initials)

CONSENT FOR TREATMENT/DIAGNOSIS, RECEIPT OF PATIENT BILL OF RIGHTS, AND FINANCIAL POLICIES

I, the undersigned patient or responsible person, having registered at *G. A. Carmichael Family Health Center* for the purpose of obtaining health services, does hereby voluntarily consent to such diagnostic and treatment services as might be provided by or at the direction of a physician, dentist or other qualified health care staff of the Health Center.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Health Center. I also recognized that I will be asked to sign a specific consent, as needed, for surgical and other special procedures including general and/or extensive local anesthesia.

I am aware that health services are not based on exact science, but are provided according to the judgment of the physician, dentist or other qualified health care staff of *G. A. Carmichael Family Health Center.* I further acknowledge that no guarantees have been made to me as to the results of any diagnostic or treatment services.

I hereby authorize *G. A. Carmichael Family Health Center* to retain, preserve and use for scientific or teaching purposes or dispose of, at their convenience, any specimen or tissue taken from my body during my treatment.

I have been given a copy of the Health Center's "Patient Bill of Rights." After reading this document, I have had a chance to ask questions. I believe I understand what the Patient Bill of Rights means. I understand what I might expect from *G. A. Carmichael Family Health Center* and what is expected of me and my family member(s) as registered patients.

I further understand that this is consent for Medical and Dental services.

I certify that this form has been fully explained to me and that I understand its contents.

Patient/Legal Guardian Signature: _____ Date: _____

G.A Carmichael Staff: _____ Date: _____

PAYMENTS ARE DUE WHEN SERVICES ARE RENDERED, THANK YOU!

G.A. CARMICHAEL FAMILY HEALTH CENTER

Put Your Family's Health In Our Hands

2020-2021

Please complete in blue or black ink.

Student Information Sheet

Student Information

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Preferred Language: English Spanish Other:

Ethnicity (Check one): ☐ Hispanic or Latino ☐ Non-Hispanic or Latina ☐ Unreported or Refused

Race (Check one): ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than One Race ☐ Unreported/Refused

Social Security Number: ____ - ____ - _____ **Date of Birth:** ____ / ____ / _____ **Sex:** Female ☐ Male ☐ Refuse to Answer ☐

Preferred Pharmacy: _____

Primary Emergency Contact

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Preferred Method of Contact | Relationship

Secondary Emergency Contact

Last Name | First Name | Middle Initial

Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

E-mail Address | Preferred Method of Contact | Relationship

Insurance

What is the name of your insurance provider: ☐ Medicaid ☐ MS Can (United Healthcare) ☐ Magnolia ☐ CHIPS (United Health)

☐ Other (Please Specify): _____

Effective Date: ____ / ____ / _____

Patient Name and Spelling on Insurance Card _____

Name of policy holder: Last Name | First Name | Middle Initial | Relationship to Patient

Address of policy holder if not the same as Patient's

City | State | Zip Code

Phone: (_____) _____ - _____

Last four digits of Policy Holder SSN: _____

Insurance Identification Number: _____

Date of birth of policy holder: _____

Group Identification Number: _____

PLEASE COMPLETE & RETURN TO SCHOOL OF GACFHC SCHOOL BASED CLINIC

rev. VC/2021

G.A. CARMICHAEL
FAMILY HEALTH CENTER
Put Your Family's Health In Our Hands

2020-2021

Please complete in blue or black ink.

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT
(MEDICAL, DENTAL, SOCIAL SERVICES, AND OUTREACH)

I, the undersigned patient or responsible person, having registered at G.A. Carmichael Family Health Center for the purpose of obtaining health services, does hereby voluntarily consent to such diagnostic and treatment services as might be provided by or at the direction of a physician, dentist or other qualified health care staff of the Health Center.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Health Center. I also recognize that I will be asked to sign a specific consent, as needed, for surgical and other special procedures including general and / or extensive local anesthesia.

I am aware that health services are not based on exact science, but are provided according to the judgment of the physician, dentist or other qualified health care staff of the Health Center. I further acknowledge that no guarantees have been made to me as to the results of any diagnostic or treatment services.

Sealants help to prevent caries (decay) in the pits and grooves of posterior (back) teeth. They do not prevent decay on all surfaces of the tooth. Proper brushing and flossing is still necessary, or decay can develop.

I hereby authorize the Health Center to retain, preserve and use for scientific or teaching purposes or dispose of, at their convenience, any specimen or tissue taken from my body during my treatment.

I further understand that this is consent for Medical, Behavioral, Nutritional, Dental and Support Services.

I certify that this form has been fully explained to me and that I understand its contents of this document and sign willingly.

▶ _____ _____ ▶ _____ _____
☒ Print Name of Patient Date ☒ Signature of G.A Carmichael Staff Date

▶ _____
☒ Signature of Parent/Guardian

CONSENT TO COMPREHENSIVE EPSDT SCREENING
I, the undersigned patient or responsible person, understand and acknowledge that, pursuant to 23 Miss. Admin. Code Pt. 223, R. 1.5, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening includes a comprehensive unclothed physical examination, which may be accomplished by examining each unclothed body system individually. I hereby voluntary consent to the comprehensive physical examination and specifically to the unclothed nature of the examination.

▶ _____ _____ ▶ Signed _____ _____
☒ Signature of Parent/Guardian Date ☒ Signature of G.A Carmichael Staff Date

LIFETIME AUTHORIZATION FOR RELEASE OF INFORMATION TO HEALTH INSURANCE PROVIDERS(S) FOR PAYMENT
I, the patient, hereby authorize any holder of medical information about me to release to the State Medicaid fiscal agent, Medicare fiscal intermediary or other insurance carrier any information needed for this or a related claim. I request that Payment of authorized health insurance benefits is made on my behalf to G.A. Carmichael Family Health Center.

▶ _____ _____ ▶ Signed _____ _____
☒ Signature of Parent/Guardian Date ☒ Signature of G.A Carmichael Staff Date

CONSENT FOR A MINOR OR LEGALLY INCOMPETENT PATIENT
I certify that I have legal capacity to give this consent for diagnostic and treatment services on the above named patient.
I recognize that according to the laws of the State of Mississippi, parental consent is not required in the case of an emancipated minor; an emancipated minor with sufficient intelligence to understand and appreciate the consequences of the proposed diagnostic or treatment services; an unemancipated minor seeking treatment of a venereal disease; or a female, regardless of age or marital status, seeking diagnostic or treatment services in connection with pregnancy or childbirth.

▶ _____ _____ ▶ Signed _____ _____
☒ Signature of Parent/Guardian Date ☒ Signature of G.A Carmichael Staff Date

▶ _____
☒ Relationship to Patient

Please complete in blue or black ink.

ACKNOWLEDGEMENT OF PATIENT BILL OF RIGHTS

I understand that a copy of G. A. Carmichael Family Health Center's Bill of Rights is posted at every GACFHC location and it is my right as a patient to request a copy for my GACFHC location.

▶_____ _____ ▶Signed _____ _____

☒ Signature of Parent/Guardian Date ☒ Signature of G.A Carmichael Staff Date

Acknowledgement of Privacy Practices (HIPAA)

The provider/practice may use or disclose the protected health information per the HIPAA Statement provided by GACFHC.

▶_____ ▶Signed _____ _____

☒ Print Name of Patient ☒ Signature of Parent/Guardian Date

▶_____ ▶_____ _____

☒ Relationship to Patient ☒ Signature of G.A Carmichael Staff Date

DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

☐ I hereby give permission to disclose personal medical information about my treatment to the following:

☐ I do **NOT** give permission to disclose personal medical information about my treatment to family members and friends:

These are the additional persons I give my permission to disclose information about my medical treatment:

Name: _____ Relationship: _____ Phone :#(___) _____

Name: _____ Relationship: _____ Phone# (___) _____

☐ Entire Medical Record ☐ Exclude Specific: _____

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY | DATE COMPLETED

BIRTH DATE | AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No · Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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