COMMUNITY HEALTH PARTNERS

New Patient Registration Form

Please Print. Complete **ALL** Sections.*

MRN: _____

PATIENT INFORMATION

Last Name:	First Name:		Middle Name:
Also Known As:	Maiden Name:		Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Registered Domestic Partner ☐ Significant Other ☐ Widowed ☐ Legally Separated ☐ Other
Social Security #:**	Date of Birth:	Age:	

Sex Assigned at Birth:	Gender Identity:	Legal/Administrative Sex:	Sexual Orientation:
☐ Male ☐ Female ☐ Not recorded at birth ☐ Uncertain ☐ Unknown	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female	☐ Male ☐ Female ☐ Nonbinary ☐ Unknown	☐ Straight ☐ Bisexual ☐ Gay ☐ Lesbian ☐ Don't know ☐ Something else ☐ Choose not to discuss

Race: ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaska Native ☐ Asian ☐ Unknown ☐ Other ☐ Prefer not to specify

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to specify

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Lao ☐ Punjabi ☐ Vietnamese ☐ Hearing Impaired/Sign ☐ Other _____ ☐ Prefer not to specify

Preferred Phone #:	☐ Home ☐ Cell ☐ Work	Second Phone #:	☐ Home ☐ Cell ☐ Work
Street Address:		P.O. Box/Apt #:	
City:	State:	Zip Code:	
E-mail Address:			
Employer:		Phone #:	
Primary Care Physician:		Phone #:	
Preferred Pharmacy:		Phone #:	
Pharmacy Location/Cross Streets:			

INJURY INFORMATION

Date of Injury:	Work Related Injury: ☐ Yes ☐ No

IN CASE OF AN EMERGENCY

Emergency Contact:	Relationship to Patient:
Home Phone #:	Work Phone #:

* Missing information may result in charges billed directly to the patient.

** Community Health Partners' electronic medical record system (EMR) requires your social security number as your unique identification number. Please help us provide you with the highest quality of care by sharing your social security number. This is very important because without your social security number as an identifier, your electronic medical record may not be complete or may contain inconsistencies. Please be confident your social security number is used only used for this purpose — it is never printed out. It is protected from misuse just as we protect your health information.

Updated 9.13.2023

New Patient Registration Form

Last Name:	First Name:	Middle Name:

INSURANCE INFORMATION Please give your insurance card to the receptionist.

Guarantor Information: ☐ **Check here if same as patient**	
Responsible Party:	Date of Birth:
Address (if different from patient):	Home Phone #:
Occupation:	Employer:
Employer Address:	Phone #:

PRIMARY INSURANCE

Insurance Company Name:		
Subscriber's Name:		Subscriber's SS #:
Date of Birth:	Group #:	Policy #:
Co-pay: $	Patient's relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other: _____	

SECONDARY INSURANCE *(IF APPLICABLE)*

Insurance Company Name:		
Subscriber's Name:		Subscriber's SS #:
Date of Birth:	Group #:	Policy #:

Patient's relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other: _____

Is this a worker's compensation claim: ☐ Yes ☐ No

Medicare Secondary Reason Code (Must check one if Medicare is Secondary):

☐ 12 Working Aged Beneficiary or Spouse with Employer Group Health Plan
☐ 13 End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
☐ 14 No-fault Insurance including Auto is Primary
☐ 15 Worker's Compensation
☐ 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
☐ 41 Black Lung
☐ 42 Veteran's Administration
☐ 43 **Disabled** Beneficiary Under Age 65 with Large Group Health Plan (LGHP—Employers with 50+ employees)
☐ 47 Other Liability Insurance is Primary (Homeowners)

What is your preferred method of communication for appointment reminders? ☐ Phone ☐ Regular Mail ☐ Web Portal ☐ Email ☐ Text Message ☐ Do Not Contact

COMMUNITY
HEALTH PARTNERS

Office Procedures and Consent

Shared Electronic Medical Records

We share an electronic medical records system with Community Medical Centers.

Smoke Free Environment

For the health of our patients, employees and visitors, smoking is not permitted at the Community Health Partners offices.

Weapon Free Environment

Weapons of any kind are not allowed at any of the Community Health Partners offices.

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a “No Show” and a $35.00 charge may be billed directly to you since it is not covered by any insurance plan.

Recording Devices Policy

Under California law, it is illegal for you to record a confidential communication without the consent of all parties involved, this includes conversations with doctors and other medical professionals. In order to protect confidential information and the privacy rights of practice providers and staff, the use of recording devices such as cell phones, audio recorders, or any other equipment used to capture or record images and/or sound by patients or visitors is prohibited. [California Penal Code Section 632.01]

Open Payments

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I have read, understand, and agree to the above.

_____ _____

Patient/Legal Representative/Guarantor Signature Date

_____

Print Name

If signed by someone other than patient, indicate relationship:

_____

COMMUNITY
HEALTH PARTNERS

Electronic Communication Exchange Consent

We offer electronic communication services via text messaging, email, and voice messaging to serve you better. Electronic communication is used for but not limited to:

- Appointment Reminders
- Patient Surveys
- General Health Tips

By providing my phone number (including a landline or a wireless phone number), I consent to receive calls (including autodialed calls and artificial or prerecorded messages) at that number from the practice and its physicians, agents and independent contractors (including services agencies and collections agencies) regarding all clinic/medical services I receive, now and in the future, and any related financial obligations.

Limitations on calls, if any: _____

_____

If I want to revoke this consent, I agree to notify my physician/provider's office.

I will also notify this office if I relinquish any phone number I give to the practice. I understand that I am not required to agree to sign the Electronic Communication Exchange Consent as a condition of receiving services at the practice.

Please list the phone numbers and email addresses you permit us to use to contact you.

Cell Phone #: _____ Land Line #: _____

Email Address: _____

_____ _____

Patient/Legal Representative/Guarantor Signature Date

_____

Print Name

If signed by someone other than patient, indicate relationship:

_____

Agreement and Authorization for Services

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to Community Health Partners, I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the Community Health Partners medical staff and personnel. I understand that some of my medical care can and will be accomplished via remote Telehealth (also known as Telemedicine) visits, and I consent to their use where deemed medically appropriate by Community Health Partners medical staff. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Release and Use of Information

I understand that Community Health Partners will record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by Community Health Partners for the purposes permitted by law and as authorized on this form. I understand that portions of my records may be disclosed to qualified non-Community Health Partners personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

I hereby authorize Community Health Partners to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning my treatment to obtain reimbursement for the treatment and services provided to me by Community Health Partners and its affiliated providers. This Agreement and Authorization for Services does not allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

III. Teaching Program

I understand that appropriately supervised residents, interns, medical students, students of ancillary health care professions (e.g. nursing, x-ray, and rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat and participate in my care as part of educational programs.

IV. Assignment of Benefits and Agreement to Cooperate in Collection Efforts

In consideration of the healthcare services provided to me ("Services") by Community Health Partners, I hereby assign Community Health Partners all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided. Community Health Partners includes, without limitation, all other physicians, physicians' assistants, nurses, therapists, laboratories, diagnostic testing entities, and all other persons or entities on whose behalf Community Health Partners provides billing services in connection with the Services. In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any reimbursement source to effectuate, perfect, confirm or validate my assignment and authorization of Community Health Partners as my assignee and authorized representative, and to assist Community Health Partners with pursuing payment from any reimbursement source.

V. Guarantee of Payment

I understand and agree that I am financially responsible for any and all charges related to any Services rendered. While my claims may be paid by the above-mentioned coverage sources, I recognize that payment is not guaranteed and that I am ultimately responsible to pay Community Health Partners the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

VI. Consent to Photograph

I hereby consent to Community Health Partners' use of digital and/or video recording of procedures and treatments provided to me for use in treatment or for health care operations purposes such as peer review or medical education.

The use of such images is subject only to the following limitations:

_____

_____

_____

The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I further understand that I must obtain consent from my treating provider(s) if I request that a procedure or treatment be photographed by CHP personnel. I also understand that the photography and photographs will be maintained in my electronic health record.

I have read each of the foregoing, I-VI and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

_____ _____

Patient/Legal Representative/Guarantor Signature Date

_____

Print Name

If signed by someone other than patient, indicate relationship:

_____

COMMUNITY
HEALTH PARTNERS

Financial and Billing Policies

Thank you for choosing Community Health Partners. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

Inform Us of Changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.

Bring Your Health Information: Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit.

Co-Payments, Deductibles and Co-Insurance: Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.

Patient Responsibility Balances: All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.

Deposits: For certain procedures, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prompt Payment: We offer a prompt payment discount. Please contact our Billing Department for details.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre-existing, or is not a covered service you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral Community Health Partners will not be reimbursed for the services provided.

Workers Compensation: Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.

Statements: You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.

Who Can Discuss a Bill: Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

I have read, understand, and agree to the above Financial and Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Community Health Partners. I authorize Community Health Partners to release pertinent medical information to my insurance company when needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform Community Health Partners of any changes regarding my personal billing information or my insurance billing information.

_____ _____

Patient/Legal Representative/Guarantor Signature Date

_____

Print Name

If signed by someone other than patient, indicate relationship:

_____

Community Health Partners complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Your provider is a member of Community Health Partners medical foundation. That means that billing statements for services provided by your physician will come from and be processed by Community Health Partners medical foundation.

Updated 9.13.2023

COMMUNITY
HEALTH PARTNERS

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Community Health Partners Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Community Health Partners may disclose and use my protected health information. I am encouraged to read the Notice of Privacy Practices in full.

Patient Name: _____ MRN: _____

Date: _____ Time: _____ Signature: _____
Patient/Legal Representative/Guarantor

If signed by the patient's legal representative/guarantor, indicate:

1. Name of Signer: _____
2. Relationship to Patient: _____

☐ Decline to sign acknowledgement or inability to obtain acknowledgement.

Community Health Partners Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice and Why it is Important

This notice is required by law to inform you of how your health information will be protected, how Community Health Partners may use or disclose your health information, and about your rights regarding your health information. The Notice covers all persons who are employees by or otherwise provide you with care through our organization. If you have any questions about this notice, please contact Community Health Partners' Privacy Office at (559) 724-4400.

Understanding Your Health Information

Each time you visit a physician, health care provider or hospital, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical records, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g., health insurance company) can verify that services you received are appropriately billed
- Tool for education health professionals
- Data source for medical research
- Source of information for public health authorities
- Source of data for planning facilities, marketing health care services, and fundraising
- Tool to facilitate routine health care
- Tool with which we can assess and work to improve the care we provide

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand, who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

You have the following rights related to your medical and billing records kept at Community Health Partners:

Obtain a copy of this notice. You will receive a copy of this notice at your first visit after its publication. Thereafter you may request a copy of this notice or any revisions from our website https://www.communitymedical.org/Privacy or by calling the Health Information Department at (559) 459-3925.

Authorization to use your health information. Before we use or disclose your health information other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosures that constitute sale of your health information.

Access to your health information. You may request a copy of your health information that Community Health Partners keeps in your medical or billing record. Your request must be submitted in writing. We charge a nominal amount for the access costs.

Amend your health information. If you believe the information we have about you is incorrect or incomplete, you may request that we correct the existing information or add the missing information. Your request must be in writing and you may pick up a form for this purpose in the Health Information Management (Medical Records) Department. We reserve the right to accept or reject your request and will notify you of our decision.

Request confidential communications. You may request in writing that when we communicate with you about your health information, we do so in a specific way (e.g., at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

Limit our use or disclosure of your health information. You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, healthcare operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services. However, if you pay out of pocket in full for the healthcare item or service then you have the right to restrict certain disclosures of your health information to a health plan.

Opting-Out of the Care Everywhere and Health Information Exchange. Community Health Partners and affiliated physicians participate in Care Everywhere (CE) and a Health Information Exchange (HIE); secure electronic systems for health care providers to share your medical information. Through CE and the HIE, your participating providers will be able to access information about you that is necessary for your treatment. You have the right to choose to have your information withheld from CE and the HIE by personally opting-out from participation. You do not have to participate in CE and the HIE to receive care. If you choose to opt-out of CE and the HIE (that is, if you feel that your medical information should not be shared through CE and the HIE), Community Health Partners and affiliated physicians will continue to use your medical information in accordance with this Notice and applicable law, but will not make it available to other health care providers through CE and the HIE. To opt-out of CE and the HIE, please request a form from Community Health Partners' Health Information Management Department at (559) 459-3925 and the form will be mailed to you.

Accounting of disclosures. You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment, or healthcare operations. Disclosures that we make with your authorization will not be listed. The first list you request within a 12 month period will be free. We may charge you for additional lists.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associates, and provide this notice about our privacy practices. In the event of any breach of unsecured protected health information, we shall fully comply with the HIPAA/HITECH breach notification requirements, which will include notification to you of any impact that breach may have had on you and/or your family member(s) and actions we undertook to minimize any impact the breach may or could have on you.

We reserve the right to change our policies and procedures for protecting health information. When we make significant change in how we use or disclose your health information, we will also change this notice. The new notice will be posted on our website, and will be available at the information desk and in our medical records departments.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization.

You have the right to revoke your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

For More Information or to Report a Problem

If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact the Health Information Department at (559) 459-3925 or the Privacy Office at (559) 724-4400.

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact Community Health Partners Privacy Officer listed at the top of the Notice of Privacy Practices. You may also send a written complaint to the:

U.S. Department of Health and Human Services
Office of Civil Rights Attn: Regional Manager
90 7th Street, Suite 4 -100 San Francisco, CA 94103
1 (415) 437-8310

Community Health Partners will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

Examples of Uses & Disclosures for Treatment, Payment & Healthcare Operations

We will use your health information to facilitate your medical treatment.
For example: Information obtained by a nurse, physician, or other members of your healthcare team will be recorded in your record and used to determine the course of your medical treatment. We will provide your physician, or other healthcare providers involved with your treatment (e.g., specialists, consulting physicians, anesthesiologists, therapists, etc.) with copies of various reports that may assist them in treating you.

We will use your health information to collect payment for health care services that we provide.
For example: A bill may be sent to you or your health insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. In some cases, information from your medical record is sent to your insurance company to explain the need for or provide additional information about your treatment. We may also disclose medical information to other healthcare providers to assist them in obtaining payment for services they have provided to you.

We will use your health information to facilitate routine healthcare operations.
For example: Members of our medical staff or quality improvement teams may use information in your record to assess the care you have received and how your progress compares to others.

We will use your health information to help us educate medical staff, residents and students.
For example: Community Health Partners has associations with a variety of schools involved in the education of health professionals. All staff, residents, and students must sign a confidentiality agreement before accessing any health information maintained by Community Health Partners.

We will use your health information to notify your family and friends about your condition or in the event of your death.
For example: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care on your general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, relevant health information to facilitate the person's ability to assist you in your care or make arrangements for payment of your care.

We may use your health information to inform persons about your death.
For example: We may disclose health information to funeral directors, coroners and medical examiners consistent with applicable law to carry out their duties.

Examples of Uses and Disclosures for Other Purposes

Appointment Reminders: We may contact you to provide appointment reminders.

Alternative Treatments: We may use your health information to provide you with information about the availability of alternative treatments that are within the range of options for your condition.

Fundraising: We are a community-based, not-for-profit organization that depends extensively on charitable support. We may disclose limited information about you, such as your name, address, demographic information, and the dates you received treatment to our fundraising foundation so that they may inform you of opportunities to support Community Medical Centers, its services and programs. You do have the right to opt out of fundraising communications.

Research: We may contact you to request your participation in an authorized research study. In some cases, we may disclose your health information to researchers when an institutional review or privacy board has approved their research. Prior to giving any information, special procedures will be established to protect the privacy of your information.

Sign in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our facility. We may also call out your name when we are ready to see you.

Workers Compensation: We may disclose your health information to your employer and workers compensation carriers as authorized by laws relating to workers compensation or other similar programs established by law.

As Required by Law: We will use and disclose your health information to comply with state and federal laws, which include reporting abuse, neglect, or domestic violence, responding to judicial or administrative proceedings, complying with audits, responding to law enforcement officials, reporting health and safety threats, reporting to public health authorities or other federal agencies.

Food and Drug Administration (FDA): We may disclose to the FDA your health information relating to adverse events with respect to food, nutritional supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Device Manufacturers: If you receive a medical device that is implanted or which is used for life support function we may disclose your name, address, and other information as required by law to the device manufacturer for tracking purposes. You may refuse to authorize the disclosure of your name and contact information.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include certain laboratory tests, patient satisfaction surveys, and the copy service we use when making copies of your health record. When these services are provided by contracted business associates, we may disclose the appropriate portions of your health information to our business associates so they can perform the job we have assigned to them. To protect your health information, however, we require all business associates sign a confidentiality agreement verifying they will appropriately safeguard your information.

Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Copeland Medical Healthcare Partners
A member of Community Health Partners
245 West Herndon Avenue
Clovis, California 93612
Office: (559) 299-1178 | Fax: (559) 326-2170

COPELAND MEDICAL
HEALTHCARE PARTNERS
A member of Community Health Partners

Primary Care Clinics Patient Questionnaire – Adult

Last Name:	**First Name:**	**DOB:**	☐F ☐M
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed		**Occupation:**	
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Immunizations: (Include approximate Year or Age)

☐ Tetanus	☐ Gardasil (HPV)	☐ Prevnar 13	☐ Hepatitis A
☐ Influenza (Flu)	☐ Pneumonia/Pneumovax	☐ Shingles vaccine/Zostavax	☐ Hepatitis B

Past or Present Medical History: (Check all that apply to you)

☐ Alcohol/Drug problem	☐ Emphysema/COPD	☐ Liver Disease	☐ Blood Clots
☐ Anemia	☐ Heart - Attack	☐ Osteoporosis	☐ Peripheral Artery Disease
☐ Anxiety	☐ Heart - Coronary Artery Dis.	☐ Prostate problem	☐ Neuropathy
☐ Arthritis	☐ Heart - Heart Failure/CHF	☐ Psychiatric - Depression	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Psychiatric Disorder-- other:_____	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Seizure Disorder	☐ Migraines
☐ Dementia	☐ Hypothyroidism (low)	☐ Stroke	☐ Hepatitis
☐ Diabetes	☐ Hyperthyroidism (high)	☐ Ulcers of the Stomach	☐ Diverticulosis
☐ Cancer-- Type: _____	☐ Kidney Disease	☐ STD/Sexual infection	☐ Colon Polyps
		☐ Abnormal Pap Test	☐ Positive TB test

Surgeries: (Include Year or Age at time of surgery)

☐ Appendectomy	☐ Tonsillectomy	☐ C-Section (Cesarean)
☐ Cardiac Bypass (CABG)	☐ Hernia Repair	☐ Hysterectomy - Partial
☐ Cardiac Angioplasty/Stent	☐ Prostate Surgery	☐ Hysterectomy - Total
☐ Gallbladder Laparoscopic	☐ Vasectomy	☐ Tubal Ligation
☐ Gallbladder Open	☐ Cataract Surgery: ☐ Left ☐ Right	☐ Breast Surgery: ☐ Left ☐ Right

Orthopedic (type):

Other Surgery:

Screening Tests	Approx Date:		**Screening Tests**	Approx Date:	
Cholesterol Test		☐ Normal ☐ Abnormal	Pap Smear		☐ Normal ☐ Abnormal
Colonoscopy		☐ Normal ☐ Abnormal	Mammogram		☐ Normal ☐ Abnormal
Prostate Test		☐ Normal ☐ Abnormal	Bone Density Test		☐ Normal ☐ Abnormal
Dental Exam		☐ Normal ☐ Abnormal			
Eye Exam		☐ Normal ☐ Abnormal ☐ Glasses ☐ Contacts ☐ Cataracts			

Last Name: _____ **First Name:** _____ **DOB:** _____

MEDICATIONS: List prescribed and over-the-counter medications.		
Drug Name:	Dose & Directions:	Reason:

ALLERGIES/REACTIONS to Medications:	
Drug Name:	Reaction/Comments :
LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:	

SEXUAL HEALTH

☐ Sexually active ☐ Not currently sexually active ☐ Never sexually active	# partners in past year:
History of Sexually Transmitted Infection? ☐ No ☐ Yes Type/date:	
Current contraception method:	Previous methods:
# children:	**For Women:** (# pregnancies:) (# miscarriages:) (# abortions:)

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, 1 - 3x/week for 30 minutes)
	☐ Regular vigorous exercise (i.e., work or recreation >3x/week for 30 minutes)

Tobacco	Cigarette use:	☐ Never	☐ Former smoker. Quit date or age:	
		☐ Current smoker:	# packs/day:	# years:
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing tobacco

Last Name: _____ **First Name:** _____ **DOB:** _____

Alcohol	Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week	
	Each week, how many: Servings of beer?_____ Glasses of wine?_____ Shots/mixed drinks? _____	
	When did you last have more than 4 drinks in one day?_____	
	Do you feel you should cut down on drinking?	☐ Yes ☐ No
	Do people annoy you by nagging about your drinking?	☐ Yes ☐ No
	Have you ever felt guilty about drinking?	☐ Yes ☐ No
	Have you ever had a morning drink to steady your nerves?	☐ Yes ☐ No

Drugs	Have you used recreational or street drugs within the last 2 years?	☐ Yes ☐ No
	Have you ever used recreational drugs with a needle?	☐ Yes ☐ No

Personal Safety	Do you wear seatbelts?	☐ Yes ☐ No
	Do you have frequent falls?	☐ Yes ☐ No
	Does your house have a working smoke detector?	☐ Yes ☐ No
	Do you experience conflicts in your relationships that take the form of verbally threatening behavior, mental abuse, physical abuse or sexual abuse?	☐ Yes ☐ No

FAMILY HEALTH HISTORY

Family Member			Age	MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer & type, etc)
Mother		☐Living ☐Deceased		
Father		☐Living ☐Deceased		
Grandmother *Mother's Side*		☐Living ☐Deceased		
Grandfather *Mother's Side*		☐Living ☐Deceased		
Grandmother *Father's Side*		☐Living ☐Deceased		
Grandfather *Father's Side*		☐Living ☐Deceased		
Sibling	☐F ☐M	☐Living ☐Deceased		
Sibling	☐F ☐M	☐Living ☐Deceased		
Sibling	☐F ☐M	☐Living ☐Deceased		
Sibling	☐F ☐M	☐Living ☐Deceased		
	☐F ☐M	☐Living ☐Deceased		
	☐F ☐M	☐Living ☐Deceased		

Reviewed by/Date: _____

Copeland Medical Healthcare Partners
A member of Community Health Partners
245 West Herndon Avenue
Clovis, California 93612
Office: (559) 299-1178 | Fax: (559) 326-2170

COPELAND MEDICAL
HEALTHCARE PARTNERS
A member of Community Health Partners

System Review for Adults – New Patient or Annual Preventive Visit

Name: _____ **DOB:** _____ **Today's Date:** _____

Check the box if you are currently experiencing any of the following:

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

SKIN:
- ☐ Rash
- ☐ New/changing skin lesion
- ☐ Nail changes
- ☐ Hair loss

EYES / EARS / NOSE / THROAT:
- ☐ Vision changes
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Lump in neck

RESPIRATORY:
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Night sweats
- ☐ Bloody sputum
- ☐ Productive cough
- ☐ Dry cough
- ☐ Shortness of breath

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or Leg swelling
- ☐ Decreased exercise tolerance
- ☐ Awakening at night due to trouble breathing

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Rectal bleeding

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

HEMATOLOGIC:
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

NEUROLOGIC:
- ☐ Headaches
- ☐ Dizziness/vertigo
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Tremor
- ☐ Frequent falls

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Insomnia/sleep problems
- ☐ Psychiatric treatment

ENDOCRINE:
- ☐ Change in appetite
- ☐ Cold or heat intolerance
- ☐ Increased thirst
- ☐ Changes in sex drive
- ☐ Hair loss or excess growth

ALLERGIC / IMMUNOLOGIC:
- ☐ Allergy/Hayfever symptoms
- ☐ Itching
- ☐ Frequent infections
- ☐ Exposure to infection

BREAST:
- ☐ Breast lump/mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Rash on breast

GENITOURINARY:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Difficulty passing urine
- ☐ Hernia

MEN:
- ☐ Difficulty starting stream
- ☐ Change in urine stream
- ☐ Penile discharge
- ☐ Testicular pain or mass
- ☐ Erection difficulties

WOMEN:
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Excessive vaginal bleeding
- ☐ Bleeding after menopause
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

Reviewed by/Date: _____