SANTA YNEZ TRIBAL HEALTH CLINIC

PATIENT INFORMATION ☐ New ☐ Annual **CHART #:** ________

Last Name: ________ First Name: ________ MI: ____ Date of Birth: ________

Gender: ☐ M ☐ F SSN#: ________ ☐ Married ☐ Single ☐ Child ☐ Other: ________

Mailing Address: ________ City: ________ Zip: ________

Phone: H ________ W ________ C ________ **Email:** ________

ETHNICITY AND HOUSEHOLD INFORMATION

RACE: ☐ Santa Ynez Chumash ☐ Other Native American / Alaskan Indian: ________

☐ Other Chumash: ________ ☐ Other (non-Native): ________

Tribal Affiliation/Name: ________ Blood Quantum: ☐ ½ ☐ ¼ ☐ Other: ________

Father's Last Name: ________ DOB: ________ Place of Birth: ________ Tribe: ________

Mother's Maiden Name: ________ DOB: ________ Place of Birth: ________ Tribe: ________

Monthly Gross Income: $ ________ Total Family Size: ________

EMPLOYMENT INFORMATION

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Employer Name: ________ Occupation: ________ Employer Phone: ________

Employer Address: ________ City: ________ Zip: ________

EMERGENCY CONTACT INFORMATION

Last Name: ________ First Name: ________ Relationship to Patient: ________

Address: ________ City: ________ Zip: ________

Phone: H ________ W ________ C ________ Best time to call: ☐ 8a-12p ☐ 12p-5p

FINANCIAL AND INSURANCE INFORMATION

SPOUSE OR RESPONSIBLE PARTY INFORMATION:

The following is for: ☐ the Patient ☐ the Patient's spouse ☐ other person responsible for payment

Last Name: ________ First Name: ________ MI: ________

DOB: ________ SSN#: ________

Address: ________ City: ________ Zip: ________

Phone: H ________ W ________ C ________ Best time to call: ☐ 8a-12p ☐ 12p-5p

INSURANCE INFORMATION:

Primary Insurance Plan: ________ ID#: ________ Group#: ________

Last Name of Insured: ________ First Name: ________ MI: ____ Date of Birth: ________

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ________

Secondary Insurance Plan: ________ ID#: ________ Group#: ________

Last Name of Insured: ________ First Name: ________ MI: ____ Date of Birth: ________

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: ________

CONSENT FOR SERVICES

- As a condition of your treatment at the Santa Ynez Tribal Health Clinic, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred on their care, and financial responsibility on the part of each patient must be determined before treatment.
- Patients who carry private insurance understand that all services furnished are charged directly to the patient and that he/she is personally responsible for payment of all services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
- A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
- In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
- I grant my permission to you or your assignee, to telephone me at my home or at my work to discuss matters related to this form.

STAFF USE ONLY:

Place stamp here:

I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT, AND BY SIGNING BELOW, AGREE TO THEIR CONTENT.

Signature: ________ Date: ________

Guarantor of payment/responsible party:

Signature: ________ Date: ________

Relationship to Patient: ☐ Patient ☐ Parent/Guardian ☐ Other:

STAFF USE ONLY:

☐ Address verified by Eligibility Specialist Signature: ________

☐ CHS or Direct Status verified Signature: ________

SANTA YNEZ TRIBAL HEALTH CLINIC
Medical Health History - Pediatric

Patient Last Name: ______________ First Name: ______________ MI: ______

Address: ______________ City: ______________ State: ______ Zip: ______

Date of Birth: ______________ Gender: ☐ M ☐ F

Family History:

Mother's Last Name: ______________ First Name: ______________ MI: ______ Age: ______

Father's Last Name: ______________ First Name: ______________ MI: ______ Age: ______

Parents are: ☐ Married ☐ Divorced ☐ Remarried ☐ Separated ☐ Single

Child primarily resides/lives with: ☐ Mother ☐ Father ☐ Both ☐ Other (specify): ______________

Others in the home:

NAME:	AGE:	RELATIONSHIP TO PATIENT:

Who cares for the child

☐ During the day: ______________ ☐ Before/After school: ______________

Birth History

Baby was delivered: ☐ C-Section ☐ Vaginal Weight: ______ lbs/oz Length: ______ in

Hospital Name: ______________ Location (city): ______________

How many days did the baby stay in the hospital? ______ days

Did the baby have any problems at or immediately after birth? ☐ No ☐ Yes (specify): ______________

Did the child's mother have any illness/problems during pregnancy or with the delivery? ☐ No ☐ Yes (specify): ______________

Development / Behavior

The Child Sat alone at: ______ Months Toilet Trained at: ______ Years

Walked alone at: ______ Months Two-word sentences at: ______ Years

Said first word at: ______ Months

Patient Health History

Has the child ever been hospitalized? ☐ No ☐ Yes

If yes, specify: When: ______ Hospital Name: ______________ Reason: ______________

Has the child ever had surgery? ☐ No ☐ Yes

If yes, specify: When: ______ Hospital Name: ______________ Reason: ______________

Does the child take medication on a regular basis? ☐ No ☐ Yes

If yes, specify: Medication Name: ______________ How Often: ______________

Does the child have any allergies to: ☐ medicines ☐ foods ☐ insect bites Specify: ______________

Does the child have/had the following conditions?

☐ Anemia	☐ Chicken Pox	☐ Hepatitis	☐ Seizures
☐ Asthma/Allergies	☐ Constipation/Diarrhea	☐ Kidney problems	☐ Skin Disease/Eczema
☐ Bedwetting/bladder issues	☐ Diabetes	☐ Lead Poisoning	☐ Speech problems
☐ Bleeding disorder	☐ Ear/Sinus infection	☐ Liver Disease	☐ Thyroid Disease
☐ Behavior problems / ADHD	☐ Hearing/Vision problems	☐ Mental Retardation	☐ Tuberculosis/ +PPD
☐ Cancer	☐ Heart problems	☐ Pneumonia	☐ Other

Family Medical History:

Do any family members or relatives have/had the following conditions?

☐ Alcoholism/Drug Addiction	☐ Cancer	☐ High Blood Pressure	☐ Mental Retardation
☐ Anemia	☐ Cystic Fibrosis	☐ High Cholesterol	☐ Migraines
☐ Arthritis	☐ Diabetes	☐ HIV / AIDS	☐ Seizures
☐ Asthma/Allergies	☐ Early Deafness	☐ Kidney Problems	☐ Thyroid Disease
☐ Birth Defects / SIDS	☐ Hearing / Eye Problems	☐ Mental Illness	☐ Tuberculosis
☐ Blood Disorder(s)	☐ Heart Disease		

TB SCREENING QUESTIONNAIRE

Today's Date: ______________________________

Full Name: ______________________________ Date of Birth: ______________

1. Have you ever had a skin test for tuberculosis (PPD)? ☐ Yes ☐ No
   If yes, when was your most recent test? Date: ______________
   What was the result? ☐ Negative ☐ Positive
2. If your TB test result was Positive, what is the date of your most recent Chest X-Ray?
   Date: ______________ What was the result? ☐ Negative ☐ Positive
3. Have you ever been treated for a Positive TB test result? ☐ Yes ☐ No
   If yes, what medication(s) were you given? ______________
   When were you treated? From: ______________ To: ______________
4. Have you ever been exposed to anyone with active Tuberculosis? ☐ Yes ☐ No
5. Have you ever lived or worked in a medical clinic or hospital, homeless shelter, drug or alcohol detox facility, or jail where you may have had direct contact with anyone infected with Tuberculosis? ☐ Yes ☐ No
6. Have you ever lived or traveled in Africa, Asia, Central America, Mexico or South America? ☐ Yes ☐ No
7. Do you have any medical illnesses of your immune system (ie: cancer, HIV (AIDS), alcohol and/or drug addiction? ☐ Yes ☐ No
8. Have you had any treatment(s) with chemotherapy or prednisone (cortisone)? ☐ Yes ☐ No
9. Have you ever received the BCG vaccine? ☐ Yes ☐ No
   If yes, when (approximate)? Date: ______________

REVIEWED BY MD: TB Risk: ☐ High ☐ Low MD Initial: ______________

This part to be completed by medical technician Test placed by: ______________

Date of Test: ______________ Dose: ______________ Site: ______________

Manufacturer: ______________ Lot #: ______________ Expiration Date: ______________

Date Read: ______________ Read By: ______________ Result: Induration: ________ x ________ mm

Interpretation: ☐ Negative ☐ Positive Action Taken: ______________

THE FORM BELOW MAY BE COMPLETED, REMOVED AND GIVEN TO THE PATIENT FOR THEIR RECORDS

Name: ______________________________ Date: ______________

TB Test (PPD) Results: ☐ Negative ☐ Positive Test Date: __________ Date Read: __________

Signature of person reading test: ______________________________

Name of Provider or Medical Clinic: ______________________________

Santa Ynez Tribal Health Clinic

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E: info@sythc.org • W: www.sythc.org

Acknowledgment of Privacy Practices, Assignment of Benefits & Health Care Directives

I understand that the information provided by me and stored in my health record is necessary for the Santa Ynez Tribal Health Clinic (SYTHC) and staff, in conjunction with Indian Health Services (IHS), to provide services for my health and well-being. I understand that my health record information is securely stored either electronically or physically, and that my health record or any portion of my health record shall not be disclosed to another agency or person(s), unless specified as routine use, without my signed consent.

I, ____, acknowledge the following:
(Print patient name or parent/legal guardian name here)

☐ I have been provided the *HIPAA Privacy Act Notice* to read.
☐ I have been provided the *Patient Rights and Responsibilities Notice* to read.

I may request a copy of either form from the receptionist if I so chose.

The Santa Ynez Tribal Health Clinic (SYTHC) is considered a training facility, and has, from time to time, non-employed staff (students, interns, interested physicians, health care representatives, surveyors, etc.) on our premises. Normally, these non-employed staff are allowed in patient care areas for observation and/or to assist a provider.

☐ I understand that I have the option, at any time, to request that non-employed staff (students, interns and/or other professionals) be excused while I am receiving direct patient care services.

____
(Initial Here)

Assignment of Benefits:
I request that payment under my medical insurance be made directly to the Santa Ynez Tribal Health Clinic. I understand that I am financially responsible when:

- My Insurance carrier does not cover a specific service;
- My insurance does not pay for services(deductible); and/or
- My insurance has been terminated.

____
(Initial Here)

Health Care Proxy/Advanced Health Care Directive:
If, at anytime, I should become temporarily or permanently unable to make healthcare decisions, my healthcare proxy shall be: ______________________________________.
(Print name here)

My healthcare proxy may make all decisions about:

- My Medical, Dental, and/or Behavioral (Mental) Health Care.

Such decisions shall be consistent with my wishes, or, if my wishes are unknown, shall be consistent with my best interest.

Print Name of Patient	Date of Birth
Signature of Patient, Parent, Guardian or Patient Representative	Today's Date
Signature and Title of SYTHC Employee	Today's Date