Santa Ynez Tribal Health Clinic

PATIENT INTAKE

Please provide us with your insurance and valid ID

PATIENT'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	NICKNAME

SOCIAL SECURITY NUMBER	BIRTHDATE	SEX ☐ MALE ☐ FEMALE	MOTHER'S MAIDEN NAME (FOR PURPOSES OF IMMUNIZATION REGISTRY)

PATIENT'S BILLING/MAILING ADDRESS

STREET OR PO BOX		
CITY	STATE	ZIP

PATIENT'S PHYSICAL ADDRESS (if different from billing/mailing address)

STREET ADDRESS		
CITY	STATE	ZIP

PATIENT'S CONTACT INFORMATION

HOME PHONE #	DAY PHONE #	ALTERNATE PHONE	E-MAIL ADDRESS

Preferred Method for Notifications (check all that apply) ☐ Phone ☐ Text ☐ E-mail ☐ Automated Recordings

PATIENT'S EMERGENCY CONTACT INFORMATION

NAME	ADDRESS	RELATIONSHIP	CONTACT PHONE NUMBER

PATIENT'S ADDITIONAL INFORMATION – For Purposes of Grant Funding

RACE
- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK/AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ MORE THAN ONE RACE

IF NATIVE AMERICAN:

TRIBE OF MEMBERSHIP:_________________

BLOOD QUANTUM:_______________

FATHER'S NAME:_______________
MOTHER'S NAME:_______________

PRIMARY LANGUAGE
- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER ___________

ARE YOU OF HISPANIC OR LATINO ORIGIN?
☐ YES ☐ NO

MARITAL STATUS
- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOW
- ☐ LEGALLY SEPARATED
- ☐ LIFE PARTNER
- ☐ OTHER ___________

HOUSEHOLD SIZE

☐ 1 ☐ 6
☐ 2 ☐ 7
☐ 3 ☐ 8
☐ 4 ☐ 9
☐ 5 ☐ 10

☐ OTHER _____

ESTIMATED HOUSEHOLD INCOME

$ ___________

- ☐ WEEKLY
- ☐ BI-WEEKLY
- ☐ MONTHLY
- ☐ ANNUALLY

ARE YOU A VETERAN OF THE U.S. ARMED FORCES?

☐ YES

☐ NO

IF YES, PLEASE PROVIDE THE RECEPTIONIST A COPY OF YOUR DD-214.

RESPONSIBLE PARTY'S INFORMATION (if different than patient)

NAME (Last, First, Middle)		PREVIOUS LAST NAME	NICKNAME
SSN	BIRTHDATE	SEX	RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS (if different than patient)

STREET OR PO BOX			
CITY	STATE	ZIP	HOME PHONE NUMBER

PATIENT'S EMPLOYER

NAME OF EMPLOYER	
TYPE OF BUSINESS	OCCUPATION
EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED	

PRIMARY INSURANCE

TYPE OF PRIMARY COVERAGE ☐ MEDI-CAL ☐ MEDICARE ☐ PRIVATE INSURANCE ☐ NONE ☐ OTHER ______________

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if applicable)

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip)	EFFECTIVE DATE	EXPIRATION DATE

CONSENT FOR TREATMENT

I, the undersigned, certify that the information contained on this form is correct to the best of my knowledge. Furthermore, I authorize the release of any medical information necessary to process the claim for treatment, payment, or operations. I authorize payment of medical benefits to Santa Ynez Tribal Health Clinic (SYTHC), provider or suppliers for services. I hereby authorize the provider and whomever else he/she may designate as his/her assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is expected at the time of service. We will bill your insurance as a courtesy. I authorize SYTHC to contact me by mobile phone. (*Standard rates may apply.*)

Patient Signature____**Date** ________________

Responsible Party's Signature____ **Date** ________________

Witness ____ **Date** ________________

Santa Ynez Tribal Health Clinic

Adult Health History

Name____ Date of Birth___________________
(month/day/year)

I. ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks):			
#	Yes	No	**Questions**
1			Do you have a primary care physician? Who?_________________________Date of last exam:______________
2			Do you have a dentist? Who?______________________________Date of last exam: _____________________
3			Have you been hospitalized or had a serious illness/injury in the last three years? Why? _____________________
4			Do you have chronic pain? When?___________________Where? ____________________________________ How often or frequent? ____
5			List current prescriptions (include vitamins, herbs, & supplements): _____________________________________

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
6			Allergies to medications	16			Allergies to food or other
7			Hepatitis	17			High blood pressure
8			Anemia	18			Kidney or bladder disease
9			Arthritis	19			Psychiatric Illness ________________________
10			Asthma or Emphysema	20			Sexual disease: Chlamydia, Herpes, etc. ______
11			Cancer, Where? ___________________	21			Skin disease or rashes
12			Diabetes or Gestational (pregnant) Diabetes	22			Stomach problems: gastritis, ulcer, other _______
13			Eye disease: glaucoma, cataract, ______	23			Stroke
14			Ear, nose or throat problems	24			Thyroid, adrenal disease
15			Heart Disease				

III. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
25			Artificial joint	29			Heart valve or pacemaker
26			Blood transfusions	30			Surgeries (including sterilization) ____________
27			Chemotherapy / Radiation	31			Domestic abuse
28			Contact lenses or glasses				

IV. WOMEN ONLY (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
32			Are you pregnant or breast feeding?	38			When was your last pap? ___________________
33			Are you taking birth control pills or shots?	39			Have you had an abnormal pap?
34			Do you have difficult periods?	40			When was your last mammogram? ___________
35			Have you had any miscarriages or abortions?	41			Have you had an abnormal mammogram?
36			More than 1 sexual partner recently?	42			Have you had a hysterectomy? Full or partial?
37			Do you have pain with intercourse?	43	At what age did you start your first period? _________________		

V. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
44			Swollen ankles	55			Dry mouth
45			Bleeding problems / bruising easily	56			Nausea and vomiting
46			Chest pain (angina)	57			Rashes
47			Cough: persistent or bloody	58			Seizures
48			Diarrhea, constipation, blood in stools	59			Shortness of breath
49			Dizziness	60			Sinus problems
50			Fever	61			Difficulty swallowing
51			Fainting	62			Excessive thirst
52			Headache	63			Frequent or bloody urine
53			Jaundice	64			Blurred vision
54			Joint pain or stiffness	65			Recent weight gain or loss

VI. OTHER INFORMATION (Check Yes or No and fill in the blanks):			
#	Yes	No	Questions
66			Do you have any other diseases or medical conditions NOT listed on this form? If so, please explain: ____
67			Please list any significant family medical history: _
68			Are you able to perform activities of daily living (ADL)? If no, please explain:
69			Do you have a religious, cultural, physical, or other factors that might influence your care? If so, please list: ____

VII. DO YOU USE ANY OF THE FOLLOWING? (Check Yes or No and fill in the blanks):							
#	Yes	No	Questions	#	Yes	No	Questions
70			Alcohol frequency ___________________	72			Tobacco (smoke or chew) ___________________
71			Caffeine frequency __________________	73			Recreational drug frequency _________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health or medications.

Patient of Guardian’s Signature____ **Date**______________________

Santa Ynez Tribal Health Clinic

Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the Federal law. We may use or disclose your personal health information for these purposes:

For Treatment, Payment, Health Care Operations, Appointment Reminders, Health Related Services and Treatment Alternatives, Fundraising Activities, Individuals Involved in Your Care or Payment for Your Care, Research, Organ and Tissue Donation, As Required By Law, To Avert a Serious Threat to Health or Safety, Military and Veterans, Workers' Compensation, Public Health Activities, Health Oversight Activities, Lawsuits and Disputes, Law Enforcement, Coroners, Health Examiners and Funeral Directors., National Security and Intelligence Activities. Protective Services for the President and Others, and Inmates.

You have certain rights with respect to your personal health information:

Right to Inspect and Request a Copy, Right to Amend, Right to Receive an Accounting of Disclosures, Right to Request Restrictions, Right to Receive Confidential Communications, Right to a Paper Copy of this Notice.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will have available a copy of our current notice in our facility. Our notice will indicate the effective date on the first page, in the center of page. We will also give you a copy of our current notice upon request.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

Ron Sisson, Executive Director
Santa Ynez Tribal Health Clinic
90 Via Juana Lane
Santa Ynez, CA 93460
(805) 688-7070

Santa Ynez Tribal Health Clinic

Acknowledgement of Receipt Privacy Practices Notice and Advance Health Care Directives Information

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:

☐ I have been provided the HIPAA Privacy Act Notice to read.

☐ I have been provided the Patient Rights and Responsibilities Notice to read.

☐ I have been provided the Advance Health Care Directive Information to read.

*****At any time, I may request a copy of any of the above documents 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 (student, 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 assistant 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.

____ ____________________

Patient's Signature Date

____ ____________________

Signature of Parent or Patient's Representative Date

Santa Ynez Tribal Health Clinic

Late Arrival Acknowledgement Form

If you arrive more than 9 minutes late to your appointment, you will be subject to the following terms:

If you are willing to wait, we will try to work you into an open slot, but this is not a guarantee.

You will also be given the option to wait on the "Stand-By" appointment list to be seen that same day with a different provider - possible wait times on the "Stand-By" list can be as long as 4 hours.

If you have 3 or more late arrivals in any 6 month period it will be counted as a No Show and be subject to the No Show Policy (available upon request).

I have read and fully understand the Santa Ynez Tribal Health Clinic Late Policy and No Show Policy and agree to follow the policy as written.

____ ______________________________

Patient Name (Print) Date

____

Patient Signature