PATIENT REGISTRATION FORM

Patient Information			
Last Name:	**First Name:**	**Middle Name**:	
Date of Birth:	**Social Security Number:**		
If Minor, Guardian Name and Relation to Patient:			
Gender Identity: ☐ Choose not to disclose ☐ Male ☐ Female ☐ Transgender ○ Male-Female ○ Female-Male ☐ Non-Binary Preferred Pronouns: ☐ she, her, hers ☐ he, him, his ☐ they, them, theirs ☐ not listed **Preferred name** :_____ (*For billing purposes the name listed on your chart will be shown as your legal name, but office staff will make notation in your chart and make every attempt to address you by your preferred name)*			
Address: ☐ Homeless	**City:**	**State:**	**Zip Code:**
Mailing Address *if different*:			
Primary Phone: ☐ Home ☐ Cell ( )	**Alternate Phone:** ☐ Home ☐ Cell ( )		
E-Mail Address:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed ☐ Other: _____			
Primary Language: **Interpreter Needed:** ☐ Yes ☐ No	**Religion:**		
Ethnicity:	**Race:** ☐ White ☐ Hispanic ☐ Native/American Indian ☐ Black-African American ☐ Asian-Pacific Islander ☐ Other:_____		
Emergency Contact			
Last Name, First Name:	**Relationship:**	**Phone Number:**	
Employment			
Employment Status ☐ Student: ☐ Full-time ☐ Part-time ☐ Retired ☐ Self-employed ☐ Employed: ☐ Full-time ☐ Part-time ☐ Unemployed			
Employer Name:	**Occupation:**		
Employer Address:	**Employer Phone:**		
Pharmacy Information			
Name:	**Address:**	**Phone Number:**	

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name: _____ DOB: _____

I give permission for Atiga Family Practice to provide my personal health information checked below

☐ Scheduling/Appointment information

☐ Medical information, including symptoms, diagnosis, medications, and treatment plan

☐ Health information, including symptoms, diagnosis, medications, and treatment plan regarding
(* items below must be checked, or this information cannot be given);
☐ Substance abuse ☐ Behavioral health ☐ Developmental disability ☐ HIV/AIDS

☐ Lab/Test results

☐ Billing and payment information

☐ All health information (* Protected health information items must be checked to give this information)

to the below named individuals/companies:

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.
Alternate date of expiration: _____

- I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Atiga Family Practice is permitted or required by law to release this information. For example, Atiga Family Practice may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Atiga Family Practice is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).
- I understand that this permission will remain in effect until the date stated above or until such time as I *revoke it in writing* (an updated agreement form will also revoke the validity of this specific agreement).

_____ _____
Patient/Authorized Representative Signature Date

If other than patient signing, state relationship: _____

☐ By checking this box, I agree that I am electronically signing this document.
☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically.

ANNUAL MINOR HEALTH HISTORY UPDATE

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Name of person completing form/
Nombre de la persona que completa el formulario: _____

Relationship to patient/Relación con el paciente:
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián

Home information/ Información de la casa:

Whom does the patient reside with? / ¿Con quién reside el paciente?
☐ Parent/Madre o Padre ☐ Grandparent/Abuela o Abuelo ☐ Sibling/Hermana o Hermano
☐ Other relative/Otro pariente ☐ Guardian/Guardiana oGuardián
How many people reside in the home/Cuantas personas residen en el hogar: _____
Parents are/ Los padres' son: ☐ Married/Casado ☐ Divorced/Divorciado ☐ Separated/Apartado ☐ Deceased/Fallecido
Is there drug, alcohol or smoking in the home?/¿Hay drogas, alcohol o fumar en casa? ☐ Yes/Sí ☐ No

Medical Diagnosis/Diagnóstico Médico

Have you been diagnosed with any new conditions since your last office visit?/ ¿Le han diagnosticado alguna afección nueva desde su última visita al consultorio? ☐ No

If yes, please list the date, diagnosis, and the provider or medical group who diagnosed you/
En caso afirmativo, indique la fecha, el diagnóstico y el proveedor o grupo médico que le diagnosticó:

Date of Diagnosis/ Fecha de diagnóstico	Diagnosis/Diagnóstico	Provider/Medical Group Name Nombre del proveedor/grupo médico

Surgeries/Cirugías

Have you had any surgeries since your last office visit? /¿Ha tenido alguna cirugía desde su última visita al consultorio? ☐ No

If yes, please list the date, surgery, and the name of the provider or medical group who performed it/
En caso afirmativo, indique la fecha, la cirugía y el nombre del proveedor o grupo médico que la realizó:

Date of Surgery/ Fecha de la cirugía	Surgery/Cirugía	Provider/Medical Group Name Nombre del proveedor/grupo médico

Hospitalizations/Hospitalizaciones

Have you been hospitalized (admitted as an inpatient) since your last office visit? ☐ No
¿Ha sido hospitalizado (admitido como paciente hospitalizado) en algún hospital desde su última visita al consultorio?

If yes, please list the dates you were admitted, the reason, and the name of the hospital/
En caso afirmativo, indique las fechas en que fue admitido, el motivo y el nombre del hospital:

ANNUAL MINOR HEALTH HISTORY UPDATE CONTINUED

Name/Nombre:	Age/Edad:	DOB/Fecha de Nacimiento:	Today's Date/Fecha:

Dates of Stay / Fechas de estancia	Reason for Hospitalization/ Motivo de la hospitalización	Name of Hospital/ Nombre del Hospital

Vaccinations/ Vacunas:

☐ **No previous vaccinations/ Sin vacunas previas**

****PLEASE PROVIDE OFFICE WITH COPY OF PREVIOUS VACCINATION****

**** POR FAVOR PROPORCIONE A LA OFICINA UNA COPIA DE LAS VACUNAS ANTERIORES ****

and TB test documents/y documentos de prueba de tuberculosis

Screenings/Proyecciones

Date last completed/Fecha de finalización por última vez

Eye exam/Examen de la vista: _____ Hearing Screen/Pantalla de audición: _____

☐ No previous eye exam/Sin examen ocular previo ☐ No previus hearing exam/ Sin examen auditivo previo

Family History/ Historia familiar

Have any family members been diagnosed with the below since your last office visit? / ☐ None, /Nada

¿Algún miembro de la familia ha sido diagnosticado con lo siguiente desde su última visita al consultorio?

If yes, please list which family member /*En caso afirmativo,* indique qué miembro de la familia

Diabetes	
High Blood Pressure/Presión arterial alta	
Heart Disease/ Cardiopatía	
Stroke/ Carrera	
Mental Illness/ Enfermedad mental	
Cancer (Also list type/También tipo de lista)	

Do you have any new concerns you would like to discuss with your provider today? ☐ No

Signature/Firma _____

☐ By checking this box, I agree that I am electronically signing this document. / Al marcar esta casilla, acepto que estoy firmando electrónicamente este documento.

☐ By checking this box, I agree that I have reviewed this document,but prefer to sign the document manually vs electronically./ Al marcar esta casilla, acepto que he revisado este documento, pero prefiero firmarlo manualmente en lugar de hacerlo electrónicamente.

Provider Signature/Firma del proveedor _____

ATIGA FAMILY PRACTICE

PATIENT NAME/ **DOB/** **TODAY'S DATE/**

Nombre del paciente: _____ **Fecha de nacimiento: _____** **Fecha: _____**

MEDICATIONS/MEDICAMENTOS

◯ No medications, vitamins or supplements taken/ No se toman medicamentos, vitaminas o suplementos

Please list ALL medicine you take including over the counter and supplements/
Por favor, enumere TODOS los medicamentos que toma incluyendo sobre el mostrador y suplmentos

Name/ el nombre	Dose/ la dosis	How often/ con que frecuencia	Taking for/ Tomar para	Prescriber/ Prescriptor

ALLERGIES TO MEDICATION/ALERGIAS A LA MEDICACIÓN

◯ No known allergies to medication/ No se conocen alergias a los medicamentos

Name of Medicine/ Nombre de la Medicina	Type of Reaction/ tip de reaccion

DURABLE MEDICAL EQUIPMENT/EQUIPO MÉDICO DURADERO

List any medical equipment you use at home? (Ex: CPAP, glucometer etc.)/
Enuniere cualguier equipo medico que use en casa (por ejemplo: CPAP, glucómetro, etc.)

◯ No Medical Equipment/Sin equipo médico

Periodic TB Risk Assessment

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

TB SYMPTOM REVIEW:

Do you currently have any of the following symptoms?	YES	NO
1. Cough that has lasted more than 3 weeks?	○	○
2. Coughing up blood?	○	○
3. Unexplained weight loss?	○	○
4. Chronic Fever?	○	○
5. Drenching night sweats?	○	○

(IMMEDIATE CXR AND MEDICAL EVALUATION IS NEEDED IF THE ANSWER IS YES TO ANY OF THE ABOVE)

NEW TB MEDICAL RISKS FOR TB DISEASE PROGRESSION:

Since your last office visit do you have a NEW diagnosis of:	YES	NO
1. HIV?	○	○
2. Diabetes?	○	○
3. Cancer?	○	○
4. Kidney Failure?	○	○

OR have you started taking any of the following IMMUNOSUPPRESSIVE MEDICATIONS:

1. Prednisone?	○	○
2. Methotrexate?	○	○
3. Cyclosporine?	○	○
4. Chemotherapy?	○	○
5. IV rheumatoid, psoriatic arthritis or Chron's disease medications?	○	○

NEW TB EXPOSURE RISK:	YES	NO
In the past 2 years …		
1. Have you had contact with anyone with known TB disease?	○	○
2. Have you spent more than 2 weeks in Asia, Africa, Latin America or Eastern Europe?	○	○
3. Have you been in incarcerated in either prison or jail?	○	○
4. Have you been homeless or living in a single room occupancy hotel?	○	○
5. Have you injected street drugs?	○	○
6. Have you worked with homeless persons, migrant workers or drug users?	○	○
7. Have you worked as a health care worker?	○	○

New or repeat TB test (Mantoux or blood test) is needed if the answer is YES to ANY of the above questions

REQUIRED: Document the patients Mantoux or blood test results in the medical record and database.

Provider Signature:_____

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ■ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

			Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?		Nutrition
2	Does your child eat fruits and vegetables at least two times per day?		
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?		
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?		
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?		
6	Does your child play actively most days of the week?		Physical Activity
7	Are you concerned about your child's weight?		
8	Does your child watch TV or play video games less than 2 hours per day?		
9	Does your home have a working smoke detector?		Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?		
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?		
12	Does your home have cleaning supplies, medicines, and matches locked away?		
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?		
14	Do you always stay with your child when she/he is in the bathtub?		

PATIENT NAME: _____ **DOB:** ___/___/___

15	Do you always place your child in a forward facing car seat in the back seat?		
16	Is the car seat you use the right one for the age and size of your child?		
17	Do you always check for children before backing your car out?		
18	Does your child spend time near a swimming pool, river, or lake?		
19	Does your child spend time in a home where a gun is kept?		
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?		
21	Has your child ever witnessed or been a victim of abuse or violence?		
22	Do you help your child brush and floss her/his teeth daily?		Dental Health
23	Does your child spend time with anyone who smokes?		Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?		Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:

Pediatric ACEs and Related Life Events Screener (PEARLS)

CHILD - To be completed by: **Caregiver**

Patient Name: _____ **DOB:** _____

At any point in time since your child was born, has your child seen or been present when the following experiences happened? Please include past and present experiences.

Please note, some questions have more than one part separated by "OR." If any part of the question is answered "Yes," then the answer to the entire question is "Yes."

PART 1:	Please check "Yes" where apply. ☑
1. Has your child ever lived with a parent/caregiver who went to jail/prison?	☐
2. Do you think your child ever felt unsupported, unloved and/or unprotected?	☐
3. Has your child ever lived with a parent/caregiver who had mental health issues? *(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)*	☐
4. Has a parent/caregiver ever insulted, humiliated, or put down your child?	☐
5. Has the child's biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?	☐
6. Has your child ever lacked appropriate care by any caregiver? *(for example, not being protected from unsafe situations, or not cared for when sick or injured even when the resources were available)*	☐
7. Has your child ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult? Or has your child ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?	☐
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at your child? Or has any adult in the household ever hit your child so hard that your child had marks or was injured? Or has any adult in the household ever threatened your child or acted in a way that made your child afraid that they might be hurt?	☐
9. Has your child ever experienced sexual abuse? *(for example, anyone touched your child or asked your child to touch that person in a way that was unwanted, or made your child feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with your child)*	☐
10. Have there ever been significant changes in the relationship status of the child's caregiver(s)? *(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)*	☐

How many "Yes" did you answer in Part 1?: ☐

Please continue to the other side for the rest of questionnaire →

This tool was created in partnership with UCSF School of Medicine.

Patient Name: _____ **DOB:** ____/____/____

PART 2:	Please check "Yes" where apply. ☑
1. Has your child ever seen, heard, or been a victim of violence in your neighborhood, community or school? *(for example, targeted bullying, assault or other violent actions, war or terrorism)*	☐
2. Has your child experienced discrimination? *(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)*	☐
3. Has your child ever had problems with housing? *(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)*	☐
4. Have you ever worried that your child did not have enough food to eat or that the food for your child would run out before you could buy more?	☐
5. Has your child ever lived with a parent/caregiver who had a serious physical illness or disability?	☐
6. Has your child ever been separated from their parent or caregiver due to foster care, or immigration?	☐
7. Has your child ever lived with a parent or caregiver who died?	☐

How many "Yes" did you answer in Part 2?: ☐

Today's Date: _____

Name of person completing form and relation to patient:

_____

Provider Signature: _____