Hyndman Family Health Center
144 5th Avenue
Hyndman, PA 15545
814.842.3206 (P)
814.842.3746 (F)

Bedford Family Health Center
104 Railroad Street
Bedford, PA 15522
814.263.5804 (P)
814.842.3746 (F)

Richland Family Health Center
214 College Park Plaza Suite 208
Johnstown, PA 15904
814.842.3206 (P)
814.842.3746 (F)

Patient Registration Information Forms

PATIENT'S NAME (PLEASE INCLUDE NAME SUFFIX IF APPLICABLE)			
LAST	FIRST	MIDDLE	MAIDEN OR SUFFIX

ADDRESS			
PO BOX/STREET	ZIP CODE	CITY	STATE

HOME PHONE NUMBER	CELL PHONE NUMBER	SOCIAL SECURITY NUMBER	SEX (CIRCLE ONE) MALE ☐ FEMALE ☐

EMAIL ADDRESS:	RACE (CIRCLE ONE) ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN ☐ ALASKA NATIVE ☐ ASIAN ☐ PACIFIC ISLANDER ☐ UNREPORTED/REFUSED

MARITAL STATUS (CIRCLE ONE) ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	BIRTHDATE	ETHNICITY (CIRCLE ONE) ☐ HISPANIC ☐ LATINO ☐ OTHER ☐ UNREPORTED/REFUSED

ALLERGIES (PLEASE CIRCLE ONE): ☐ YES ☐ NO **IF YES, PLEASE LIST**:	VETERAN (CIRCLE ONE) ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION			
CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
RESPONSIBLE PARTY (Required if patient is under age 18)		DATE OF Birth	SOCIAL SECURITY NUMBER

NOTIFICATION AUTHORIZATION

This is to obtain your preference for notification of lab and x-ray results or regarding information about medications (please check in the appropriate area)

( )1. Try to contact me by telephone, but if you do not reach me directly, **do not** leave any type of message on the answering machine or with person answering the telephone

( )2. If you do not reach me directly, by telephone, HAHC may leave actual results on answering machine or with person answering the telephone

( )3. I would like to make other arrangement (please specify):

_____

_____

_____

PATIENT'S EMPLOYMENT INFORMATION	
OCCUPATION	EMPLOYER'S NAME

EMPLOYER'S ADDRESS

STREET	ZIP CODE	CITY	STATE

EMPLOYER'S PHONE NUMBER

GUARANTOR/PRIMARY INSURANCE CARDHOLDER'S INFORMATION

LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE

SOCIAL SECURITY NUMBER	OCCUPATION	SEX (CIRCLE ONE) MALE ☐ FEMALE ☐

GUARANTOR'S EMPLOYER NAME	EMPLOYERS' PHONE NUMBER

GUARANTOR'S EMPLOYER ADDRESS

PO BOX/STREET	ZIP CODE	CITY	STATE

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

INSURANCE STREET ADDRESS	ZIP CODE	CITY	STATE

SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

DENTAL INSURANCE INFORMATION (if applicable)

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

INSURANCE STREET ADDRESS	ZIP CODE	CITY	STATE

PRESCRIPTION INSURANCE INFORMATION (if applicable)

PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

INSURANCE STREET ADDRESS	ZIP CODE	CITY	STATE

SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

PATIENT'S PHARMACY INFORMATION

PHARMACY NAME	PHARMACY TELEPHONE NUMBER

ADDRESS:	ZIP CODE	CITY	STATE

This information is required as HAHC submits prescriptions electronically.

Income Verification

HAHC offers a sliding fee scale based on income and family size to all patients. To see if you will qualify please complete the following. **Proof of income will be required before receiving the sliding fee discount.**

Your Family Size and Income – first find and circle your family size, then go across that line, find and check the annual income range for your family.			
☐ Family size 1 person:	☐ $0 - $12,490	☐ $12,490 - $24,980	☐ $24,980 & above
☐ Family size 2 people:	☐ $0 - $16,910	☐ $16,910 - $33,820	☐ $33,820 & above
☐ Family size 3 people:	☐ $0 - $21,330	☐ $21,330 - $42,660	☐ $42,660 & above
☐ Family size 4 people:	☐ $0 - $25,750	☐ $25,750 - $51,500	☐ $51,500 & above
☐ Family size 5 people:	☐ $0 - $30,170	☐ $30,170 - $60,340	☐ $60,340 & above
☐ Family size 6 people:	☐ $0 - $34,590	☐ $34,590 - $69,180	☐ $69,180 & above
☐ Family size 7 people:	☐ $0 - $39,010	☐ $39,010 - $78,020	☐ $78,020 & above
☐ Family size 8 people:	☐ $0 - $43,430	☐ $43,030 - $86,860	☐ $86,860 & above
For each additional person over 8 family members add: $4,420			

How did you hear about the health center (please circle):

- ☐ Friend or Family Member
- ☐ Newspaper or advertising
- ☐ Insurance company
- ☐ Doctor referral
- ☐ Other (please list) _____

CONSENT, ASSIGNMENT AND RELEASE

1. I _____ give permission for Hyndman Area Health Center, Inc. to give me treatment.
(patient name)

2. I request that payment of authorized benefits is made on my behalf to the Hyndman Area Health Center, Inc. for any services rendered to me by their medical and/or dental providers. I authorize Hyndman Area Health Center, Inc. to release medical and/or dental information to my current insurance company and its agents to determine these benefits or the benefits payable for related services.

I understand that:

- Hyndman Area Health Center will have to send my health information to my insurance company.
- I must pay my share of the costs when I receive my treatment.
- I must pay for the cost of these services if my insurance does not pay after 90 days or if I do not have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.
- I may request a copy of HAHC's Notice of Privacy Practice at any time.

4. I have read the consent to treat or have had this consent read to me.

5. I have been able to ask questions and my questions were fully answered.

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date
(for children under 18)

_____
Print Name

Initial Health History

Name _____
First Middle Last

Today's Date _____ Date of Birth _____

Address _____

Telephone Number home (___) _____
cell (___) _____
work (___) _____

GENERAL HEALTH

Why did you make this appointment? (Check all that apply.)

- ☐ regular checkup
- ☐ first appointment to start care with a new doctor
- ☐ switching doctors: from whom: _____
- ☐ have a specific health problem: if so, explain _____

In general, what do you consider to be your main health problem(s)? (Check all that apply.)

- ☐ heart problems
- ☐ stomach problems
- ☐ ear, nose, or throat problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ depression/emotional problems
- ☐ joint problems
- ☐ breathing problems
- ☐ thyroid problems
- ☐ Other(s) – please explain _____

How would you describe your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription medicines?

- ☐ Yes. Please list your medicines below OR ☐ I brought my pill bottles or a list.
- ☐ No, I do not take any prescription medicines.

Name of medicine	Amount (mg/mcg/IU)	How many pills or doses do you take at
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

Please use the back of this form if you have more prescription medicines

What over-the-counter medicines do you take regularly?

- ☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, and Aspirin)
- ☐ Vitamins
- ☐ Antacid (for example: Tums, Prilosec)

☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None - I do not take any over-the-counter medicines regularly.

Have you ever had any **allergic reaction (bad effects)** to a medicine or a shot?
☐ Yes. (Please write the name of the medicine and the effect you had.)
☐ No, I am not allergic to any medicines.

Medicine I am allergic to	What happens when I take that medicine

Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)
☐ latex (rubber gloves)
☐ grass or pollen
☐ eggs
☐ shellfish
☐ Other (please describe) _____
☐ No - I have no allergies that I know of.

Have you ever been a **patient in a hospital** overnight?
☐ Yes. (If yes, explain EACH reason and when.)
☐ No, I have never been a patient in a hospital.

I was in the hospital because:	When

SURGICAL HISTORY

Have you ever had a surgery? ☐ Yes (if yes, please list below with dates) ☐ No

Surgery	Year

Have you ever had a ☐ colonscopy ☐ sigmoidoscopy?
When _____
Was it abnormal? ☐ Yes ☐ No

Have you ever received a **blood transfusion**? ☐ Yes ☐ No
When_____

Do you have **advanced directives** in place (DNR, living will, etc.)? ☐ Yes ☐ No
What do you have in place? _____

FOR WOMEN ONLY

Age at start of periods: _____ First day of last menstrual period: _____ Age at end of periods:_____
Do you have problems with your periods or birth control? ☐ No ☐ Yes _____

If post menopause or over age 50, do you take:
Calcium ☐ Yes ☐ No Estrogen ☐ Yes ☐ No Progesterone ☐ Yes ☐ No

Have you ever been **pregnant**? ☐ Yes ☐ No
How many times?_____
How many children have you given birth to?_____

Have you had a **Pap smear**? ☐ Yes ☐ No
Date of last one _____

Have you ever had a **Pap smear that was not normal**? ☐ Yes ☐ No

Have you had a **mammogram**? ☐ Yes ☐ No
Date of last one_____

Have you had a **DEXA scan**/bone density test? ☐ Yes ☐ No
Date of last one_____

MEN ONLY

Have you had a PSA blood test? ☐ Yes ☐ No
Was it abnormal? ☐ Yes ☐ No
Date of last one _____

Have you had a digital rectal exam? ☐ Yes ☐ No
Was it abnormal? ☐ Yes ☐ No
Date of last one _____

IMMUNIZATIONS

When was your last **Tetanus shot**? Year_____ ☐ never ☐ don't know

When was your last **Pneumonia shot**? Year_____ ☐ never ☐ don't know

When was your last **Flu shot**? Year_____ ☐ never ☐ don't know

Other shots you have had (please check all that apply)

☐ Hepatitis A series ☐ MMR
☐ Hepatitis B series ☐ Meningitis

SOCIAL HISTORY

What language do you prefer to speak? _____

Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8 — Grade School
9 10 11 12 — High School
GED
1 2 3 — Vocational School
1 2 3 4+ — College

What do you do during the day?

☐ Work full-time ☐ Work part-time ☐ Attend school
☐ Caregiver ☐ Stay home ☐ Other _____

Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?

☐ No ☐ Yes

a. When did you start?_____
b. How much per week? _____
c. Have you quit? ☐ No ☐ Yes, when_____
d. Do you want to quit ☐ No ☐ Yes ☐ Already Quit

Do you drink **alcohol**?

☐ No ☐ Yes

a. Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No
b. Have people ever annoyed you by criticizing your drinking? ☐ Yes ☐ No
c. Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
d. Have you ever had a drink first thing in the morning? ☐ Yes ☐ No

Do you or any household members use **illegal drugs**: ☐ No ☐ If yes, who? _____
What type of drugs do you or your household members use? _____

Do you or any household members have an addiction to prescription medications?

☐ No ☐ if yes, who _____
What kind of prescription medications? _____

Caffeine use: ☐ None ☐ Coffee/Soda/Tea _____ cups/day

Do you exercise? ☐ if no, why _____ ☐ yes, I exercise

How often? _____ What kind of exercise? _____

Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed

Spouse/Partner's Name: _____

Who lives in your house?_____

Are you sexually active? ☐ Yes ☐ No ☐ Not currently

Do you have sex with ☐ men ☐ women ☐ both ☐ neither

Birth control method: _____

In the past year, have you been emotionally or physically abused by your partner or someone important to you? ☐ Yes ☐ No

Occupation: _____ Employer: _____

FAMILY HISTORY: Please list family members (mother, father, sister, brother, aunt/uncle, grandparents)

Alcoholism	High cholesterol
Cancer (type)	High blood pressure
Heart disease	Stroke
Depression	Bleeding disorder
Bipolar Disorder	Schizophrenia
Genetic Disorder	Asthma/COPD
Diabetes	Crohn's Disease
Other (s):	

PERSONAL MEDICAL HISTORY: Have you had any of the following medical conditions? (Mark all that apply)

☐ Anemia	☐ Asthma	☐ Diabetes (sugar)	☐ Irritable Bowels
☐ Heart Trouble	☐ Hemorrhoids	☐ Cancer	
☐ Hepatitis	☐ Tuberculosis	☐ Liver Trouble	
☐ Pneumonia	☐ Rheumatic fever	☐ Ulcers	
☐ Stroke	☐ High Blood Pressure	☐ Anxiety	
☐ Skin problems	☐ Depression/Bipolar Disorder	☐ Epilepsy	
☐ Sexually Transmitted Infections	☐ Crohn's Disease/Colitis	☐ COPD	

REVIEW OF SYSTEMS: Please check any CURRENT symptoms you have

CONSTITUTIONAL
- ☐ Weight Loss /Gain
- ☐ Fatigue
- ☐ Fever/Chills

RESPIRATORY
- ☐ Cough/Wheezing
- ☐ Coughing up blood

HEMATOLOGY/LYMPH
- ☐ Easy Bruising
- ☐ Blood Gums Bleed Easily
- ☐ Enlarged glands

EYES
- ☐ Glasses/Contacts
- ☐ Eye Pain
- ☐ Double Vision
- ☐ Cataracts

MUSCULOSKELETAL
- ☐ Joint Pain/Swelling
- ☐ Recent Back Pain

GASTROINTESTINAL
- ☐ Acid Reflux
- ☐ Nausea/Vomiting/Diarrhea/ Constipation
- ☐ Abdominal Pain
- ☐ Blood or change in bowel movements

EAR,NOSE,THROAT
- ☐ Difficulty Hearing/Ringing in ears
- ☐ Hay fever/Allergies/Congestion

SKIN
- ☐ Rash/Sores
- ☐ New or change in mole
- ☐ Warts

NEUROLOGICAL
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting/Falling

GENITOURINARY:
- ☐ Burning/Frequency
- ☐ Blood in Urine
- ☐ Nighttime Urination
- ☐ Abnormal Discharge
- ☐ Leaking urine/weak urine stream
- ☐ Unusual vaginal bleeding

HEART
- ☐ Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of Breath with Activity

PSYCHIATRIC/EMOTIONAL
- ☐ Anxiety/Stress
- ☐ Sleep problems

ENDOCRINE
- ☐ Cold/Heat Sensitive
- ☐ Increased Thirst/Appetite

BREAST
- ☐ Breast Lump
- ☐ Nipple Discharge

Signature of person completing this form: _____

Reviewed by Provider: _____

Comments or Special Instructions:

_____

_____

_____

_____

Signature – Self/Parent/Guardian

Date:	
Patient Name:	Date of Birth:

MESSAGE AUTHORIZATION

If we need to contact your, may we leave a message at your:

Home Telephone Number Yes ____ No____ ( ) _____

Cell Phone Number Yes ____ No____ ( ) _____

Employer Phone Number Yes ____ No____ ( ) _____

REQUEST FOR SPECIAL PERMISSION

I understand that my physician may use or disclose my protected health information (PHI) for the purpose of treatment, payment and health care operations. My physician may also disclose information to someone involved in my care or the payment for my care, such as a family member or friend.

I hereby permit HAHC to disclose this information to the following people:

Persons Name	**Relationship to Patient**

Comments or special instructions

_____ _____

Signature of patient or his/her authorized representative Date

Patient Bill of Rights

- To receive quality medical and dental care regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
- To be treated with respect by Hyndman Area Health Center.
- To information contained in your medical record. You also have the right to participate in decisions involving your health care.
- To personal privacy. Any discussion, consultation, examination and/or treatment regarding your care will be done discreetly.
- To confidentiality of your medical record and other information related to your medical condition.
- To be seen in a safe and clean environment.
- To have special needs met, such as an interpreter to help with communication.
- To appoint a person to make health care decisions on your behalf in the event you lose the ability to do so.
- To make advance directives regarding your medical care and have them honored.
- To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

Your responsibilities as a Patient are:

- To provide, to the best of your knowledge, complete information about your symptoms, past illnesses, medications and other matters relating to your plan of care.
- To schedule and keep doctor/dentist appointments, or call to cancel your appointment if you cannot be there.
- To notify the Network of any changes in address, family members or insurance coverage (provide a current copy of insurance card).
- To ask questions when you do not understand explanations about your care or services.
- To be responsible for your actions if you refuse treatment or do not follow your physician's/dentist's instructions.
- To follow the organization's policies.
- To be courteous and considerate of Hyndman Area Health Center personnel and other patients.

October 2013

What is a Federally Qualified Health Center?

- **A Federally Qualified Health Center is a partnership between patients, the government, and communities that work together to best meet health care needs.**
    - They constitute a vital safety net in the nation's health delivery system that works to meet escalating health needs, reduce health disparities, and bring doctors and health services into medically underserved areas. Today this growing nationwide network of over 1,200 Health Centers serve more than 18 million people at 7,000 urban and rural communities in all 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.

- **Federally Qualified Health Centers fill critical gaps in health care by serving the working poor, the uninsured, and the medically underserved as well as many other high-risk and vulnerable populations.**
    - Federally Qualified Health Centers serve as family medicine providers to one of every 7 uninsured persons, one of every 6 low-income Americans, and one of every 7 rural Americans who otherwise would lack access to health care. In addition, health centers and their innovative programs in primary care and prevention reach out to more than 600,000 homeless persons and 700,000 migrant and seasonal farm workers.

- **Federally Qualified Health Centers are built by community initiatives. Federal grants provide money which empowers communities to recruit providers and other health professionals. These federal grants also help communities to build their own points of entry into the nation's health care delivery system.**
    - Federal grants constitute an average 25 percent of a Health Center's budget. The remainder is leveraged from state and local governments, Medicare and Medicaid, private contributions, private insurance, and patient fees. Medicaid is the largest source of revenue averaging 35 percent of total revenue.

- **Federally Qualified Health Centers make a large contribution to communities by keeping the doors of health care open to all who seek their care.**
    - It is estimated that Health Centers save the health system and American taxpayers seven billion dollars per year by keeping people healthy and out of costly hospital and emergency room visits. Patients are charged on a sliding fee scale to ensure that income or lack of insurance is not a barrier to care. The Health Center approach is aimed at lowering the costs of disease through accessible and affordable primary care and prevention.

- **Federally Qualified Health Centers are community driven and patient centered.**
    - Health Centers tailor services to fit the special needs and priorities of their communities. Serving high-risk and vulnerable populations, Centers integrate the delivery of primary care with patient outreach, education, translation, and support services to make health care responsive and cost effective. Their innovative programs are designed to ensure that patients have access not only to medical treatment but a continuum of coordinated care and vital support services that can lead to positive health outcomes and healthier behaviors and lifestyles.

- ***Federally Qualified Health Centers enable communities and their residents to make health and disease prevention a priority.***
    - Health Centers interact with schools, businesses, community organizations, foundations, and state and local governments. They bring communities together in the effort to develop locally responsive strategies that can effectively meet special needs and address costly and devastating health problems which include

substance abuse, domestic violence, infant mortality, homelessness, and AIDS. They are strong partnerships that join the public and private sectors to support community initiatives for better health.

- **Federally Qualified Health Centers hold high standards of accountability for patient care and effective use of public and private funds.**
    - Governed by volunteer consumer boards comprised of patients and civic leaders, Health Centers ensure that care is patient-centered and responsive to diverse cultures and needs within the communities served.

- **Federally Qualified Health Centers allow for cost savings within their communities and the nation.**
    - Health Centers significantly increase the use of preventive health services such as immunizations, Pap smears, mammograms, and glaucoma screenings. In addition, Health Centers save the Medicaid program at least 30 percent in annual spending for its beneficiaries due to reduced specialty care referrals and fewer hospital admissions. It is estimated that Health Centers save almost 3 billion dollars annually in combined federal and state Medicaid expenditures.

- **Federally Qualified Health Centers are vital mainstays in America's communities.**
    - Health Centers contribute to the health and well being of their communities by keeping children healthy and helping adults remain productive and on the job. They recruit and train health professionals for service in rural and medically underserved areas. Likewise, Health Centers provide jobs for 70,000 individuals, most of who are community residents, and engage citizen participation and involvement. Moreover, Health Centers are engines of economic development in their communities spending nearly 6 billion dollars a year, with combined payrolls exceeding 4 billion dollars and generating more than 20 billion dollars in economic output for low-income communities across the nation.

America's Federally Qualified Health Centers have produced a model of health care that has demonstrated that this nation can meet compelling health needs while decreasing health care costs. The Health Center legacy proudly shows the value and vast potential of a community-based health system that is lifting the barriers to health care, safeguarding health, revitalizing communities, and keeping people healthy at cost savings for the nation.

HAHC
INCORPORATED