Redwoods Rural Health Center Patient Health History

Medical Clinic (707) 923-2783 Dental Clinic (707) 923-4313

Please answer the following questions. For Yes/No questions, please mark each question individually.
If you are not sure about a question, please circle the number or letter in front of the question.

Patient Name: First _____ Last _____

Names used previously: _____ Phone: _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Email:** _____

1. Why are you here today? _____

2. When was your last health exam? _____ **3. Who is your doctor?** _____

4. When was your last dental visit? _____ **5. Who is your dentist?** _____

6. Medical History: Have you ever had…

	No	Yes/Year
A. **Damaged or artificial heart valve**		
B. Congenital heart lesion or murmur		
C. Cardiovascular heart disease		
1. Chest pain during/after exertion		
2. Shortness of breath		
3. Swelling of ankles or feet		
4. **Cardiac pacemaker**		
D. Abnormal blood pressure (high or low)		
E. Lung trouble, Asthma, Tuberculosis, COPD		
F. Sinus problems		
G. Hives or skin rash		
H. Allergy		
I. Diabetes		
1. Frequent urination (more than 6 X per day)		
2. Frequent thirst/dry mouth		

	No	Yes/Year
J. Hepatitis A, B, or C		
K. Arthritis		
L. Rheumatism or painful swollen joints		
M. **Joint prosthesis**		
N. Endocrine disorder, thyroid		
O. Stomach ulcer		
P. Kidney trouble		
Q. Persistent or bloody cough		
R. **Fainting spells or seizures**		
S. **Cancer/Radiation**		
T. HIV or AIDS		
U. **Blood disorder, anemia or hemophilia**		
1. Abnormal bleeding with surgery or trauma		
2. Bruising easily		
3. Blood transfusion		
V. Family member w/bleeding disorder		

7. Medications: ☐ Check here if you do **NOT** take **ANY** medications (please provide complete med list on next page)

Are you taking…	No	Yes
A. Anti-biotics or Sulpha Drugs		
B. Anticoagulants (blood thinners)		
C. Medicine for high blood pressure		
D. Cortisone or other steroids		
E. Sleeping Medications		
F. Antihistamines		
G. Aspirin		

	No	Yes
H. Insulin or diabetes drugs		
I. Heart Drugs, nitroglycerin, digitalis		
J. Oral Contraceptives		
K. Other medications		
L. Bisphosphonate (for Osteoporosis)		
M. Chemotherapy (or previously)		

Patient Name:_____ DOB: _____

8. Medications ☐ No Medications

Brand Name	Generic Name	Start Date	Directions
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

9. Allergy ☐ No allergies

Name	Reaction	Name	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

10. Past Medical History ☐ No known past medical history

Condition	Year Began
1.	
2.	
3.	
4.	
5.	
6.	

11. Past Surgeries ☐ No past surgeries

Surgery	Year
1.	
2.	
3.	
4.	
5.	
6.	

12. List hospitalizations in the past 5 years:

Reason	What Hospital	Date

13. Female Patients:

LMP: __/__/__ Currently Pregnant: Y/N Breast Feeding: Y/N

Please indicate # of: Pregnancies: _____ Live Births: ____ Ectopic: ____ Miscarriages: ____ Abortions: ____

14. Family History ☐ **No relevant family history** ☐ **I am adopted/fostered**

Diagnosis	Family Member	Comments
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Patient Name:_____ DOB: _____

Social History

15. Alcohol Use ☐ yes ☐ no ☐ former

Type	
Drinks per Day	
Year Quit	

16. Tobacco Use ☐ yes ☐ no ☐ former

Type of tobacco	
# Used per Day	
Years Used	
Year Quit	

17. Health Maintenance Last Test Date:

Cholesterol Check	
PSA	
Colonoscopy	
Bone Density Scan	
Ultrasound Liver Test	
Tetanus Vaccine	
Hepatitis Test	
HIV Test	
Anemia Test	

18. Disease Management Last Test Date:

HgbA1C	
Abdominal Ultrasound	
Cardiac Stress Test	
Chest X-ray	
Echocardiogram	
EKG	
Eye Exam	

19. List any other diseases or problems which might be of concern:

_____

_____

20. Advance Directives (Resuscitation Wishes)

Date Reviewed: _____ ☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy

***I have filled out this health history completely and accurately to the best of my knowledge.**

_____ _____
Signature (Patient or Responsible Party) **Date**

_____ _____
Printed Name of Responsible Party **Relationship to Patient**

----------Office Use----------

Review Date: _____ Provider: _____ **Review Date: _____ Provider: _____**
Review Date: _____ Provider: _____ **Review Date: _____ Provider: _____**
Review Date: _____ Provider: _____ **Review Date: _____ Provider: _____**

REDWOODS RURAL HEALTH CENTER
101 WEST COAST ROAD/PO BOX 769 REDWAY, CA 95560

PATIENT INFORMATION FORM

PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY #:_____
MAILING ADDRESS: _____ DRIVER'S LICENSE #: _____
CITY: _____ ZIP_____ DATE OF BIRTH: _____ SEX: M☐ F☐
PHYSICAL ADDRESS: _____ MARITAL STATUS: SNGL☐ MRD☐ DIV☐ WDW☐
CITY: _____ ZIP: _____ SPOUSE'S NAME: _____
PHONE NUMBER: _____ EMPLOYER: _____
EMAIL: _____ WORK PHONE: _____

IN ORDER FOR US TO MEET FEDERAL FUNDING REQUIREMENTS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

ARE YOU A VETERAN OF THE UNITED STATES OF AMERICA? YES☐ NO☐

ARE YOU A SEASONAL AGRICULTURAL WORKER? YES☐ NO☐

ARE YOU HOMELESS (LACK HOUSING OR LIVING IN TRANSITIONAL HOUSING) YES☐ NO☐

RACE/ETHNICITY: WHITE☐ HISPANIC☐ AFRICAN AMERICAN☐ NATIVE AMERICAN☐
CHINESE☐ JAPANESE☐ FILIPINO☐ OTHER ASIAN☐ DECLINE TO ANSWER☐

MONTHLY INCOME

CIRCLE YOUR FAMILY'S MONTHLY GROSS INCOME LEVEL THAT CORRESPONDS TO YOUR HOUSEHOLD SIZE					
HOUSEHOLD SIZE	**AT OR BELOW**	**BETWEEN**	**BETWEEN**	**BETWEEN**	**ABOVE**
1	$981	$982-$1354	$1355-$1471	$1472-$1962	$1963
2	$1328	$1329-$1832	$1833-$1991	$1992-$2655	$2656
3	$1674	$1675-$2310	$2311-$2511	$2512-$3348	$3349
4	$2021	$2022-$2789	$2790-$3031	$3032-$4042	$4043
5	$2368	$2369-$3267	$3268-$3551	$3552-$4735	$4736

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME: _____ SOCIAL SECURITY #:_____
MAILING ADDRESS: _____ DRIVER'S LICENSE #: _____
_____ DATE OF BIRTH: _____ SEX: M☐ F☐
CITY: _____ ZIP_____ MARITAL STATUS: SNGL☐ MRD☐ DIV☐ WDW☐
PHYSICAL ADDRESS: _____ SPOUSE'S NAME: _____
CITY: _____ ZIP: _____ EMPLOYER: _____
PHONE NUMBER: _____ WORK PHONE: _____

IF PATIENT IS UNDER 18

MOTHER'S NAME: _____ FATHER'S NAME: _____
MAILING ADDRESS: _____ MAILING ADDRESS: _____
CITY: _____ ZIP:_____ CITY: _____ ZIP:_____
HOME PHONE: _____ HOME PHONE: _____
WORK PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT

_____

NEAREST RELATIVE (OUTSIDE OF HOUSEHOLD) CITY & STATE PHONE NUMBER

□Private Pay □CMSP/*Issue Date:* _____/ ____/ ____ □Medicare #_____

□Insurance □MediCal/*Issue Date:* _____/ ____/ ____ □Other: _____

If you are covered by Insurance, Medi-Cal or Medicare, *please* present your card to the receptionist.

We have a sliding-fee scale for low-income patients. Please tell the receptionist if you are interested in this program.

Payment for office examinations and treatment is required at the time services are rendered unless other arrangements have been made

I, the undersigned, give my permission for Redwoods Rural Health Center to administer medical care, and agree to be responsible for payment of all Health Center Services

_____ _____/ _____/ _____

Signature of Patient, Parent or Legal Guardian Date

Pursuant to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Redwoods Rural Health Center does not discriminate on the basis of race, color, national origin, handicap, or age.

INSURANCE OR MEDICARE SECONDARY INSURANCE INFORMATION

We are happy to assist you in submitting your insurance claims; however, please remember that you are responsible for ensuring that Redwoods Rural Health Center is paid for services provided to you. If your insurance carrier does not pay us within 60 days, it becomes your responsibility to do so and contact your insurance company to find out why payment has not been made. We will reimburse you when your insuance carrier remits a payment.

Your Insurance Carrier:_____ID# _____ Group #_____

Policy Holder: □Self □Spouse □Parent □Other Policy Holder Name: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

AUTHORIZATION FOR RELEASE

I HEREBY AUTHORIZE the release of any and all information acquired in the course of examination/treatment, to my insurance company.

I HEREBY AUTHORIZE and request the payment of medical benefits directly to Redwoods Rural Health Center for medical services rendered to me. This assignment will remain in effect until revoked by me in writing. A photocopy or scan of this agreement is to be as valid as the original.

_____ _____/ _____/ _____

Signature of Patient, Parent or Legal Guardian Date

SIGNATURE FOR INFORMED CONSENTS

I have had the opportunity to read the following informed consents:

Please **initial and sign.**

____ 1) The Redwoods Rural Health Center "No Show Policy"

____ 2) Notice of Privacy Policies

____ 3) Consent for Local Anesthesia (for Dental only)

____ 4) The Dental Material Facts Sheet (for Dental only)

Patient/Guardian Signature _____ Date _____

Patient's printed name _____ Date _____

In order to save paper, these materials may be viewed in our Clinic upon your arrival or downloaded and viewed from our website.

Website Address: http://www.rrhc.org/forward/

Look under the Download Forms section.

Redwoods Rural Health Center

Sliding Scale Application

Head of Household Information:

Name: (First, middle initial, Last):	Social Security Number:	Date of birth:	County:
Mailing Address:	City/State/Zip:	Home Phone:	Work Phone:
Homeless/Transitional Housing: Yes/No	Marital Status: : Single ❑ Widowed ❑ Divorced ❑		
# of people living in the home that share household expenses:	Married ❑ Separated ❑		

Income Information: Please complete for all adult household members who are employed: **PROOF OF GROSS INCOME MUST BE PROVIDED TO RRHC (RECENT PAYSTUB, INCOME TAX RETURN, STATEMENT OF FEDERAL OR STATE DEPOSITS). PERSONS NEEDING TO SELF DECLARE ARE REQUIRED TO MEET WITH A PATIENT SERVICES ASSISTOR** Otherwise, services will be rendered at the full charge.

Employed Person	**Company Name**	**Income (Before Taxes)**	**Paid how often? (Check One)**
		$	❑ Weekly ❑ 2 times per month ❑ Monthly ❑ Every 2 weeks
		$	❑ Weekly ❑ 2 times per month ❑ Monthly ❑ Every 2 weeks
Other sources of income:	Alimony $	TANF $	Pension/Retirement $
Child Support $	Disability $	S.S.I. $	Social Security $
Unemployment $	Other $	Other $	Other $

Household Information: List ALL individuals in household, including the head of household.

Name	**Date of Birth**	**Relationship**	**Age**	**Income**	**Employed**
1.					**Yes/No**
2.					**Yes/No**
3.					**Yes/No**
4.					**Yes/No**

***** List additional Persons on Back of Application***

Applicant Signature_____ **Date** _____/___ /_____

FOR OFFICE USE ONLY

- ❍ Patient has been approved for sliding-fee scale: A ❑ B ❑ C ❑ D ❑ E ❑
- ❍ Patient applied for Medi-Cal or Covered CA (circle program) App Date: _____
- ❍ Patient denied Medi-Cal coverage (copy of denial attached)
- ❍ Patient has met Share-of-Cost or Deductible and is not eligible for the sliding-fee program.
- ❍ Patient's income is too high to qualify for the sliding-fee program.
- ❍ Patient declined to provide income information or refused to complete the eligibility form.
- ❍ Patient has declined the sliding fee

____ ____ _____

Staff Signature _____ Date _____