Name ____

WELCOME!

Dear Patient:

Welcome to Neighborhood Health Services! All of us here at NHS –Doctors, nurses, front office staff, and administrators—will do our best to take care of your health care needs. But before we begin, we will need some information from you.

Please go through the rest of this packet and complete the forms as thoroughly as you can. If you have any questions, ask our staff.

When you are ready to register, we will need the following documents:

- **Proof of Identification.** This can be a driver's license, a social security card, a birth certificate, or another form of photo ID.
- **Proof of Residency.** For example: a current driver's license, utility bill, property tax statement, or a voter's registration card.
- **Proof of Income.** For example: a check stub or a letter from your employer. If you do not have any income, you can bring in a notarized letter stating so, from whomever is giving you assistance.

If you do not have any of these items with you on your initial visit, you must bring these items with you to your follow-up visit in order to continue to receive services.

Please be in the office at least 20 minutes prior to all appointments. Patients arriving more than 10 minutes late will be rescheduled. If you need to cancel or re-schedule your appointment, please call us at (850) 224-2469 at least 24 hours in advance.

Let our office staff know if there are any problems during your visit, and please take the time to fill out our Patient Questionnaire to let us know how we are doing.

Thank you, and welcome to NHS!

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Neighborhood Health Services

Patient Registration

Patient Name____

Social Security#:____

Sex: Male_______ Female___________ Date of Birth: _______________Race:____________

Marital Status: ___________________________

Address: ____ City: ___________________________________

State: ____ Zip: ____

Home Phone: _______________________________ Alternate Phone:_______________________________________

Emergency Contact Person: __________________________________Phone Number: _________________________

Employer: ____ Work Phone: ______________________________

Work Address: ____

Total household Income: $________________________ Number of people in household: _______________________

Head of Household- MALE OR FEMALE (PLEASE CIRCLE ONE)

Additional Income Information:

AFDC: $___________________________________ Social Security: $___________________________________

SSI: $_______________________________________ Child Support: $ ___________________________________

Pension: $ __________________________________ Self – Employment: $_______________________________

Unemployment: $____

Do you need help with translation? Yes _________________________ No _____________________________

Do you need help with transportation? Yes _______________________ No _____________________________

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Patient Registration Continued

Primary Insurance (If you have no insurance, skip the rest of this form and sign below.)

Company: ____

Medicare Number: ____

Medicaid Number: ____

Contract Number: ____

Group Number: ____

Subscriber: ____

Name of Insured: _______________________________ Employer: ___________________________

Relationship to Patient: _______________ DOB: __________________ SSN: ________________________

Address (if different from above):

____

City: __________________________ State: ___________ ZIP: ___________ Phone: ____________________

Additional Insurance Information

Company: ____

Medicare#: ____

Medicaid#: ____

Contract Number: ____

Group Number: ____

Subscriber Number: ____

Name of Insured: _______________________________ Employed: ___________________________

Relationship to Patient: __________________ DOB: __________________ SSN: ________________

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Neighborhood Health Services

Patient Registration Continued

Address (if different from above)

Address: ____

City: ____________________________________ State: ______________________________

ZIP: ______________________________ Phone: ___________________________________

I, the undersigned, certify that all of the information provided above is accurate. I understand that I am financially responsible for any and all charges not covered by my insurance or the program for which I qualify. I hereby authorize Neighborhood Health Services to release any information to collect payment of benefits. I authorize the use of this signature on all payment and insurance submissions.

___________________________________ ___________________________________

Patient's Signature Date Witness's Signature Date

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Neighborhood Health Services

Patient Health History

Patient's Name: ____Date:__________________

Social Security Number: ______________________________ Date of Birth: _______________

Health Maintenance: When you were last vaccinated against the following:
Flu: _______________ Tetanus: ____________ Pneumonia: _________ TB Skin Test:______________

Other: ____

When was your last:
Eye Exam: _________ Breast Exam:__________ Pap Smear:__________ Sigmoidoscopy:____________
Complete Physical Exam: ___________

Have you ever had any of the following:
Chicken Pox ______ Measles _______ German Measles _____ Mumps ______ Scarlet Fever ________
Rheumatic Fever ________ Tuberculosis ________ Whooping Cough_________ Hepatitis B__________

Personal Habits: Please indicate if you consume any of the following and in what amounts:

Coffee/Tea/ Soda: ______Number of Cups/day: ______ Tobacco: ______ Number of Packs/ day: ______

Alcohol: _________ Amount/week: ___________ Street Drugs:_____________

Are you sexually active? _________________________ Number of partners:________________________

Are your partners: Male ___________ Female____________ Both______________

Females Only

Age of Onset Menses (menstrual cycle): __________ Age of Menopause:_________

Birth Control Method:_______________ Number of Pregnancies: _______ Number of Births:_________

Numbers of Miscarriages:_________ Number of Terminated Pregnancies: _________

Please list the reasons that you are here to see the doctor:

____

____

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

New Patient Health History Continued

Health History: Please indicate if you have had any of the following conditions:

Condition	Yes	No
Fever		
Weight Problems		
Bruise or Bleed easily		
Swollen Glands		
General Weakness		
Aches/Pain		
Blood Transfusions		
Vision Change		
Ear Pains		
Buzzing/Ringing Ears		
Sinus Problems		
Swallowing Problems		
Decreased Hearing		
Mouth/Tooth/Tongue/Problems		
Persistent Hoarseness		
Severe Headaches		
Rash/ Hives		
Changing Moles		
Skin Cancer		
Other Skin Problems		
Irregular Heart Beat		
Shortness of Breath		
Low Exercise Tolerance		
Chest Pain		
Frequent Coughs		
Coughing up Blood		
Wheezing		
Swollen Ankles		
Exposure to TB		
High Blood Pressure		
Indigestion/Heartburn		
Nausea		
Vomiting Blood		
Abdominal Pain or Cramps		
Abnormal Pap Smear		
Diarrhea or Constipation		

Condition	Yes	No
Bowel Habit Changes		
Rectum Blood Passage		
Black Tar Type Bowel		
Hernia		
Hepatitis/Jaundice		
Up Nights to Urinate Frequently		
Blood in Urine		
Burning or Pain while Urinating		
Problem passing urine		
Kidney Stones		
Leg or Arm Weakness		
Balance Problems/Dizziness		
Fainting Spells		
Convulsions/Seizures		
Memory Loss		
Joint Pain		
Joint Swelling		
Muscle Strength Loss		
Gout		
Back Pain		
Phlebitis		
Leg Cramps		
Is your Life Satisfactory?		
Anxiety		
Depression		
Bipolar illness		
Have You Considered Suicide?		
Lump in Testicles		
Penis Discharge or Sore		
Sexually Transmitted Disease		
Sexual Concern		
Breast Lump(s)		
Unusual Nipple Discharge		
Vaginal Discharge		
Hot Flashes		
Bloating, Irritability w/Periods		

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

New Patient Health History Continued

Family History: Please indicate which Blood Relatives-if any-have suffered from the following:

Alcoholism______ Arthritis______ Asthma _____ Cancer _____ Diabetes _____ Glaucoma________

Epilepsy/Seizures ______ Gout ______ Hypertension_____ Heart Attack _______ Kidney Disease ______

Mental Illness _______ Migraine________ Stroke ________ Suicide ________ Tuberculosis/ TB________

Hospitalizations:

Please list the year and reason for any hospitalizations or major Surgeries:

YEAR	HOSPITALIZATION/OPERATION	YEAR	HOSPITALIZATION/OPERATION

Medical Illnesses:

Please list any chronic Illnesses and indicate how long you have had them:

1		3	
2		4	

Allergies:

Please list all medications that you are allergic to and the reaction:

	Medications That You Are Allergic to:	Reaction:
1		
2		
3		
4		
5		

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Medications:
Please list all Medications you are currently taking, including non-prescription drugs such as cold medications, antacids, laxatives or vitamins:

1		9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8		16	

Current Pharmacy Information:

Pharmacy Name: ________________________ Pharmacy Phone Number: ________________________

_______________________________________ _______________________________________
Patient's Signature Date Nurse's Signature Date

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

General Consent for Treatment

I, the undersigned, grant permission for myself or minor child to undergo all necessary test, examinations, treatments, and other procedures required in the course of study, diagnosis, and treatment of illnesses by medical practitioners and other staff members of Neighborhood Health Services, Inc.

I am aware that the practice of medicine and minor surgery is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments or examinations by Neighborhood Health Services, Inc.

I consent to the release of medical information to the patient's insurer or to authorized institutions or agencies that accept the patients for medical treatment and I furthermore give permission to release data (medical and personal) to such government agencies as required by Neighborhood Health Services, Inc.

I hereby authorize payment to neighborhood Health Services, Inc. of benefits otherwise payable to me including Medical or Medicare benefits, but not to exceed the regular charges for this period of treatment.

______________________________ ______________________________
Patient's Name (Printed) Social Security Number

______________________________ ______________________________
Patient's Signature Date

______________________________ ______________________________
Witness's Signature Date

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Client Participation Agreement

Applicant Name: ___________________________ Social Security Number ___________________________

This is to certify that the patient listed above and the following members of his or her family may receive services from Neighborhood Health Services, Inc. from __________________ until______________________.

Eligible Family Members:

Name	Social Security Number	Date of Birth
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Neighborhood Health Services offers the following services:

Physical Exams

Prescription Medication

Health Education

Eye Care Screenings

Well and Sick Care

Screenings

Nutritional Counseling

Health & Hygiene Items

Mental Health Services

Medical Follow-ups

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Client Participation Agreement Continued

These services have been explained to me. I certify that all information I have given regarding income and family size is true and correct to the best of my knowledge. I understand that although I or members of my family may be referred for specialty care, hospitalization, or other higher levels of care, there is no obligation for the provider to pay for these services. I understand that I am responsible for my family and myself. I will notify Neighborhood Health Services, Inc. when one of my family members cannot keep an appointment. Should I not utilize the services of Neighborhood Health Services, Inc. for a two year period; a letter will be sent advising me of the need to re-determine my eligibility. I understand that if I do not respond within two weeks, my name will be removed from the client list; this does not prevent me from re-enrolling as an active client in the future.

_______________________________ _______________________________
Patient's Signature Date

_______________________________ _______________________________
Witness's Signature Date

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Use and Disclosure of Protected Health Information to Family Members and Others Who May Be Involved in Your Care

Patient Name: _____________________________ Medical Record Number:_______________________

As a patient of Neighborhood Health Services, Inc. you may wish to authorize the disclosure of information related to your care to family members or other individuals. To protect your privacy while facilitating this communication, we will require you to list the name(s) of those individuals who are authorized to communicate with our caregivers and staff about results, appointments, findings, treatments, referrals and other inquires.

In order to verify that the caller has the right to this information, our staff may ask some questions to verify the identity. However, such persons may be contacted if needed based on the professional judgment of our caregivers and staff.

If you decline this disclosure, Neighborhood Health Services, Inc. will not answer to any inquiries from family members or other individuals.

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency

Name ____

Yes, I want my protected health information disclosed to the following family members or other individuals.

Name	Relationship to Patient
1.	
2.	
3.	
4.	

______________________________ ______________________________
Patient/Legal Representative Signature Date

______________________________ ______________________________
Witness's Signature Date

No, I do not want my protected health information disclosed to any of my family members or other individuals.

______________________________ ______________________________
Patient/Legal Representative Signature Date

______________________________ ______________________________
Witness's Signature Date

438 West Brevard Street
Tallahassee, Florida 32301
850.224.2469 (Phone) 850.224.1139 (Fax)
A United Way Agency