



SAMUEL DIXON FAMILY HEALTH CENTERS, INC.
PATIENT REGISTRATION FORM

Please note that the following information is confidential and is used only for our health center statistics.

PATIENT NAME: _____

ADDRESS: _____
City State Zip

1. Telephone No. _____ D.O.B. _____ Birth Gender: _____ SSN #: _____

2. Single _____ Married _____ Divorced _____ Widowed _____ Other _____

3. Email Address: _____

4. Emergency Contact: Name: _____ Phone: _____ Relation: _____

5. Gender of the Head of your Household: Male ___ Female ___

6. What is the Head of your Household's Occupation: _____ Your Occupation: _____

7. Are you a Migrant Worker? Yes ___ No ___ Are you a US Veteran? Yes ___ No ___

8. Do you consider yourself to be homeless? Yes ___ No ___ Are you a public housing resident? Yes ___ No ___

9. Do you consider yourself to be disabled (check all that apply)? Mentally ___ Physically ___

10. Do you have an Advance Directive? Yes ___ No ___ OFFICE USE ONLY: Information given? Yes ___ No, patient declined ___

11. What is your primary written and spoken language? English ___ Spanish ___ Other _____

12. Do you consider yourself to have limited English proficiency? Yes ___, translator needed. No ___

13. Mother's Name and Maiden Name: _____

Racial Background

Mark X next to all that apply:

- American Indian / Alaska Native
Asian
Black / African American
Native Hawaiian / Other Pacific Islander
White

Ethnic Background

Please choose one:

Are you Hispanic/Latino?

- Yes
No

Decline to State Race/Ethnicity

Sexual Orientation (circle one): Straight Gay/Lesbian Bisexual Something else Don't know Decline to state

Gender Identity (circle one): Male Female Transgender Male Transgender Female Other Decline to state

14. Person responsible for payment: _____

15. Your principal Health Insurance Coverage: _____

16. Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

I certify under penalty that my total income is \$ _____ monthly for my entire family size and that there are _____ dependents including myself living in the home. If applicable, as proof of income I will provide the health center with up to three of the most recent check stubs or a copy of my last year's income tax return.

I certify that the above information is true and accurate and that supporting documentation can be provided upon request.

Authorization: I hereby authorize Samuel Dixon Family Health Centers to furnish information to insurance carriers concerning this illness/accident, and hereby assign to the health center all payment for medical services. I understand that I am responsible for all the charges whether or not covered by my insurance.

**Samuel Dixon Family Health Center, Inc.
Privacy Notice Acknowledgement**

My signature below shows that I have read or have had the notice of privacy practice explained to me and I understand my rights.

I give my consent to SAMUEL DIXON FAMILY HEALTH CENTER, INC. to release my health information for the reasons of treatment, payment, or for audits by agencies funding our operation or providing benefits. All others must be authorized by me in writing. I can revoke this additional authorization at any time.

Signed

Date

Print Name

Phone Number

If not signed by the patient, indicate relationship:

_____ Parent or guardian or minor child

_____ Guardian or conservator of an incompetent patient

Indicate name of patient _____

This acknowledgement will be kept in the patient record.

NPP Information given to patient



Samuel Dixon Family Health Centers, Inc.

Val Verde

30257 San Martinez Road
Val Verde, CA 91384
Tel: 661-257-4008
Fax 661-257-3056

Newhall

23772 Newhall Ave.
Newhall, CA 91321
Tel: 661-291-1777
Fax: 661-255-1208

Canyon Country

27225 Camp Plenty Road, Suite 2
Canyon Country, CA 91351
Tel: 661-424-1220
Fax: 661-424-1273

PATIENT CONSENT FORM

I hereby consent to any necessary medical or surgical treatment, which may include prescribed medications issued by the provider. I understand that even simple treatments or diagnostic measures have a risk of complications. In such cases, further consultation with the provider may be necessary. Samuel Dixon Family Health Centers, Inc., will make referrals for specialized services that we are unable to provide here. Information obtained by Samuel Dixon Family Health Center is confidential. Medical records will not be released without written consent from the patient, parent, or guardian if the patient is a minor.

I acknowledge that any additional release of my information must be authorized by me, in writing.

I understand I also have the right to refuse or terminate care and services at any time.

Please be aware that occasionally we are asked to release information in an audit by agencies funding our services; or by insurers providing benefits, without seeking prior consent.

- If patient is unable to sign, please have a responsible person sign as a witness
- Parent or guardian's signature is required if the patient is a minor

Date: _____

Signature: _____

Witness: _____

PERSONAL MEDICAL HISTORY (Continued)

NAME:

CHART NUMBER:

IMMUNIZATIONS:	YES	NO	Date		Yes	No	Date		Yes	No	Date
Tetanus				Flu/Influenza				Pneumonia			
Measles				Rubella				Polio			
Tuberculosis (BCG)				Hepatitis				Other:			
FAMILY HISTORY:		If Living, Age & Health		If Deceased, Age at Death & Cause		HAS ANY BLOOD RELATIVE HAD:					
									Yes	No	Who
Father's Father:								Heart Attack			
Father's Mother:								Heart Disease			
Mother's Father:								High Blood Pressure			
Mother's Mother:								Stroke			
Father:								Breast Cancer			
Mother:								Cancer			
Brother(s)								Type -			
								Insulin Diabetes			
								Non-Insulin Diabetes			
Sister(s):								Sickle Cell Disease			
								Asthma			
								Tuberculosis			
Son(s):								Thyroid Disease			
								Emotional Disorders			
								Alcohol/Drug Abuse			
Daughter(s):								Migraine Headaches			
								Bleeding Tendencies			
								Other:			
Spouse:											
HABITS: SMOKING -									YES	NO	
Do you smoke now?											
Did you ever smoke?											
How much do/did you smoke? (packs per day)											
For how long? (years) _____ If you quit, what year? _____											
What do/did you smoke? () cigarettes () cigars () pipe											
DRINKING -									YES	NO	
Do you drink alcohol?											
Have you ever had a drinking problem?											
How often do you drink alcohol? () rarely () 1X/month () 1X/week () more than 5X/week											
What do you drink? _____ How many cups of coffee a day? _____											
DRUGS -									YES	NO	
Do you use recreational drugs?											
What do you use? _____											
How often? () rarely () monthly () weekly () daily											
EXERCISE -									YES	NO	
Do you exercise regularly?											
What type of exercise? _____											
How often? _____											
SAFETY -											
Do you wear seat belts? () never () rarely () sometimes () most times () always											
RELATIONSHIP -											
What is your sexual preference? () men only () women only () both											
Number of sexual partners in the last year? () 0-1 () 2-5 () more than 5											

**SAMUEL DIXON FAMILY HEALTH CENTER
REVIEW OF SYSTEMS**

NAME: _____ DATE: _____ CHART #: _____

PLEASE LIST YOUR IMMEDIATE COMPLAINTS: _____

*** PLEASE INDICATE THOSE CONDITIONS OCCURRING IN THE LAST SIX MONTHS***

SKIN -	YES	NO	CARDIO/PULMONARY -	YES	NO	GENERAL/ENDORCRINE -	YES	NO
Rashes			Chest pain			Recent weight change		
Acne			Easily short of breath			Contantly hot or cold		
New/Changing Moles			Sleep on several pillows			Fevers/chills/sweats		
EYES -	YES	NO	Swollen feet/legs			Very fast or slow pulse		
Glasses/Contacts			Heart murmur			Increased hunger/thirst		
Changing vision			Chronic cough			Excessive urination		
Eye Pain			Heart palpitations			Fatigue		
EARS -	YES	NO	Cough up blood			Change in appetite		
Losing hearing			Weezing			Swollen glands		
Buzzing in ears			STOMACH/INTESTINES -	YES	NO	GENITAL/URINARY -	YES	NO
Frequent infections			Frequent heartburn			Burning on urination		
NOSE -	YES	NO	Persistent nausea			Blood in urine		
Frequent bleeding			Constipation			Loss of urine		
Sinus trouble			Diarrhea			Night time urination		
Prolonged congestion			Change in stools			Sexual difficulty		
THROAT -	YES	NO	Blood in stools			FEMALE -	YES	NO
Change in voice			Black/tarry stools			Change in periods		
Hoarseness			Gray/white stools			increased pain/cramps		
Trouble swallowing			Hemorrhoids			Vaginal discharge		
BACK/LIMBS/JOINTS -	YES	NO	Abdominal pain/cramping			Painful Intercourse		
Swollen/Painful Joints			NEUROLOGICAL -	YES	NO	MALE -	YES	NO
Persistent Back Pain			Frequent headaches			Lumps/pain in testicles		
Injury			Fainting/blackouts			Penile discharge		
MENTAL HEALTH -	YES	NO	Memory loss			Difficulty in starting or stopping urine flow		
Trouble sleeping			Dizziness					
Suicidal thoughts			Numbness/tingling			OTHER PROBLEMS/CONCERNS -		
Depression			Balance problems					
Family problems			BREASTS -	YES	NO			
Drug problems			Lumps/pain/discharge					