The WELLNESS Clinic

(PATIENT DEMOGRAPHIC STICKER)

PATIENT DEMOGRAPHIC FORM

First Name_____ Last Name _____ MI ___ Preferred Name _____ DOB ___/___/_____
(Legal) (Legal)

Address _____ City _____ State _____ Zip _____ SSN ___-___-____ Age _____
☐ Homeless

Email _____ Primary Phone _____ Secondary Phone _____

Emergency Contact _____ Contact Number _____ Relationship to Patient _____

PLEASE CHECK ALL THAT APPLY

Gender Identity	**Sexual Preference**	**Gender At Birth**	**Marital Status**	**Medical Insurance Status**
☐ **Male**	☐ **Men**	☐ **Male**	☐ **Single/Not Married**	☐ **Uninsured**
☐ **Female**	☐ **Women**	☐ **Female**	☐ **Divorced/Separated**	☐ **Medi-Cal/Medicaid**
☐ **Trans-MTF**	☐ **Men & Women**	☐ **Decline to State**	☐ **Live-in with partner**	☐ **Medicare**
☐ **Trans-FTM**	☐ **Questioning**		☐ **Married**	☐ **Public Insurance**
☐ **Decline to State**	☐ **Asexual**		☐ **Domestic Partnership**	☐ **Government Insurance**
☐ _____	☐ **Decline to State**		☐ **Civil Union**	☐ **Other** *(Please Specify)*
			☐ **Decline to State**	_____

Race	**Specific Ethnicity**		**Primary Language**	**HIV Status**	**Employment Status**
☐ **American Indian/Alaska Native**	☐ **Burmese**	☐ **Laotian**	☐ **English**	☐ **Negative**	☐ **Employed**
☐ **Asian**	☐ **Cambodian**	☐ **Malaysian**	☐ **Mandarin**	☐ **Positive**	☐ **Student**
☐ **Native Hawaiian/Pacific Islander**	☐ **Chamorro**	☐ **Mein**	☐ **Cantonese**	☐ **Untested**	☐ **Unemployed**
☐ **Black/African American**	☐ **Chinese**	☐ **Samoan**	☐ **Tagalog**	☐ **Unknown**	☐ **Decline to State**
☐ **White/Caucasian**	☐ **Fijian**	☐ **Singaporean**	☐ **Japanese**		
☐ **Latino/Latina**	☐ **Filipino/a**	☐ **South Asian**	☐ **Korean**	**Last Tested:**	**Occupation:**
☐ **Don't know**	☐ **Hawaiian**	☐ **Taiwanese**	☐ **Samoan**		
☐ **Decline to State**	☐ **Hmong**	☐ **Thai**	☐ **Hawaiian**	_____	_____
☐ **Other (specify):**	☐ **Indonesian**	☐ **Tongan**	☐ **Vietnamese**	(Est. Date)	
_____	☐ **Japanese**	☐ **Vietnamese**	☐ **Other**		
	☐ **Korean**	☐ **West Asian**			
	☐ **Other Asian**	☐ **Other**			

CONSENT FOR TREATMENT: I hereby authorize the Wellness Clinic to perform all medical treatment which may be deemed necessary or advisable. I also certify that all the information I have provided is true and correct. I understand that I may receive services provided by interns/trainees/volunteers in multiple health professions who are under direct supervision by the Clinic Administrator and/or Director of Health Services. It is understood A&PI Wellness Center reserves the right to submit claims to patients' insurance upon disclosure.

_____ _____ _____

SIGNATURE OF PATIENT OR GUARDIAN **PRINT NAME** **DATE**

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The WELLNESS Clinic

PATIENT HEALTH HISTORY

	Yes	No		Yes	No
Allergies?			Have you ever had a significant head injury?		
Medications? (list here)			Having pain anywhere? Where is it painful?		
Coughing over 14 days?			Problems with feet or legs?		
Coughing up blood?			Trouble walking/Balance?		
Unexplained weight loss (10lbs or more?)			Experiencing any symptoms of swelling/numbness/tingling?		
Night sweats or fever?			History of seizures?		
Ever treated with medicine for TB?			Do you have heart disease?		
Change in appetite?			Do you have pain or fluttering in chest?		
Any lung problems/shortness of breath?			High blood pressure?		
Rash, itching, or open sores?			Diabetes?		
Unexplained diarrhea or constipation?			Any history of domestic violence?		
Cold/Chills?			Do you have a Primary Care Physician? (who/where)		
Vomiting or abdominal pain?			Have you been vaccinated against Hepatitis A and B?		
Problems urinating?			Have you been tested for HIV in the past 6 months?		
Menstruation/period problems?			What is the reason for your visit today?		
Pregnant? Due Date:_____					
Prenatal care?					

PATIENT SIGNITURE: _____ DATE: _____

Administrative Use Only

Comments:_____

_____

_____

Screened by: _____ Reviewed by: _____Date: _____

PATIENT CONSENT AGREEMENT

In accordance with the HIPAA acknowledgement of 1996, it is the responsibility of *Asian & Pacific Islander Wellness Center*, to confirm patient privacy and confidentiality of your health records.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, understand that as part of my healthcare, *Asian & Pacific Islander Wellness Center,* originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the many health professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my records.
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

In signing this form, I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment and healthcare operations and that the organization is not required to agree to the restrictions requested. _____ **(PATIENT/CLIENT INITIAL)**

I hereby consent for *Asian & Pacific Islander Wellness Center* to preview my personal pharmaceutical history, if deemed necessary. _____ **(PATIENT/CLIENT INITIAL)**

OPTIONAL EMERGENCY CONTACT RELEASE

I hereby authorize the release of any and all information related to my medical record to the following individual. _____ **(PATIENT/CLIENT INITIAL)**

Emergency Contact _____ Phone _____

Relationship to Patient _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE WITNESS

Acceptance of Policy: _____ Date: _____

Denial of Policy: _____ Date: _____