Sunshine FAMILY CARE

Date Form Completed _____

The information in your medical record is confidentialand is protected. Your written consent will be required for release of information except in the case ɗa court order.

Patient Registration

Legal Name* Last	First	Middle Initial	**Preferred Name:**
Legal Sex (please check one) * ☐ Female ☐ Male **While Sunshine recognizes several genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must beused on documents pertaining to insurance, billing, and correspondence. If your preferred name and pronouns are different from these, please let us know.*			**Pronouns:**
Date of Birth Month/Day/Year / /	**Social Security #**		**State ID # or License #**

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ☐ Yes ☐No	**Cell Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Work Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Best number to use:** ☐ Home ☐ Cell ☐ Work
Address	City	State	ZIP
Email address: **Insurance Carrier Name** _____		**Insurance #** _____	
Secondary Insurance Name _____		**MIDAP #** _____	
Occupation	Employer/School Name		
Emergency Contact's Name	Phone Number		Relationship to you
***Sunshine Family Care will send certain correspondence, such as bills, to your mailing address*. How would you prefer to receive written correspondence? (check one)** ☐ Secure Email (Health Portal) ☐ Letter ☐ Other _____			

This information is for demographic purposes only and will not affect your care.

1.) What is your annual income? **$**_____ ❑ No income. If no income, who helps supports you? _____ _____	**2.) Employment Status** ❑ Employed full-time ❑ Employed part-time ❑ Student full time ❑ Student part time ❑ Retired ❑ Unemployed ❑ Other _____	**3.) Racial Group(s)** (check all that apply) ❑ African American / Black ❑ Asian ❑ Caucasian / White ❑ Native American / Alaskan Native / Inuit ❑ Pacific Islander ❑ Other _____	**4.) Ethnicity** ❑ Hispanic/Latino/Latina ❑ Not Hispanic/Latino/Latina
5.) List Primary Language if other than English. ❑ Other _____ Do you need interpretation services? ☐ Yes ☐ No	**7.) Do you think of yourself as:** ❑ Lesbian, gay, or homosexual ❑ Straight or heterosexual ❑ Bisexual ❑ Something else ❑ Do not know	**8.) Marital Status** ❑ Married ❑ Partnered ❑ Single ❑ Divorced ❑ Widowed **9.) Veteran Status** ❑ Veteran ❑ Not a Veteran	**10.) Referral Source** ❑ Self ❑ Friend or Family Member ❑ Health Provider ❑ Emergency Room ❑ Ad/Internet/Media Outreach ❑ Work or School ❑ Other _____
11.) What is yourgender? ☐ Female ☐ Male ☐ Genderqueer or not exclusively male or female	**12.) What was your sex assigned at birth?** ☐ Female ☐ Male	**13.) Do you identify as transgender or transsexual?** ☐ Yes ☐ No ☐ Do not know	 **Please turn over**

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Date Form Completed _____

Patient Medical History/Review of Systems

An accurate medical, social, and family history is very important for Sunshine Family Care to better assess your current medical health and influences on future health and well-being.

1.) Please mark any of the following that you are currently having.

- ❑ Tiredness
- ❑ Fever
- ❑ Night Sweats
- ❑ Weight Gain
- ❑ Weight Loss

2.) Eyes

- ❑ Blurred Vision
- ❑ Eye Drainage
- ❑ Eye Pain
- ❑ Light Sensitivity
- ❑ Double Vision

3.) Ear, Nose and Throat

- ❑ Hearing Problems
- ❑ Ear Ringing
- ❑ Nosebleeds
- ❑ Hoarseness
- ❑ Sore Throat

4.) Heart, Cardiovascular

- ❑ Chest Pain/ Pressure
- ❑ Dizziness
- ❑ Palpitations
- ❑ Feet Swelling
- ❑ Varicose Veins

5.) Respiratory

- ❑ Cough
- ❑ Shortness of Breath
- ❑ Blood-colored sputum
- ❑ Wheezing

7.) Gastrointestinal

- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Blood in Stool
- ❑ Nausea
- ❑ Vomiting

8.) Genitourinary

- ❑ Painful to urinate
- ❑ Blood in urine
- ❑ Frequent Urination
- ❑ Unable to hold urine
- ❑ Pain in your back in Kidney area

9.) Musculoskeletal

- ❑ Joint Pain
- ❑ Back Pain
- ❑ Joint Stiffness
- ❑ Pain in Arms or Legs
- ❑ Muscle Pain

10.) Skin/Breast

- ☐ Sores
- ☐ Moles
- ☐ Itching
- ☐ Rash
- ☐ Breast Pain/Tenderness
- ☐ Breast Lump

11.) Neurological

- ☐ Fainting
- ☐ Headaches
- ☐ Confusion
- ☐ Memory Loss
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures

12.) Hematological/Endocrine

- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Lymph Node Swelling
- ☐ Anemia

13.) Psychologic

- ❑ Depression
- ❑ Anxiety
- ❑ Severe Stress
- ❑ Sleep Disturbance

14.) Allergies

- ❑ None
- ❑ Latex
- ❑ Food

Medications: *Please List all Medications Allergies*

_____

_____

Sunshine FAMILY CARE

Date Form Completed _____

15.) Prescriptions, Including over the counter medications, Vitamins, and Supplements.

Name of Medication	Reason	Dosage	How Many Per Day

Preferred Pharmacy	Address	Phone Number
Name:		

Past Medical History

1.) Please mark if you have had:

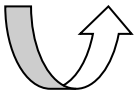
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Difficulties
- ❑ Depression
- ❑ Diabetes
- ❑ Insomnia/Difficulty Sleeping
- ❑ Kaposi's sarcoma
- ❑ Emphysema
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ High Cholesterol
- ❑ Pneumonia
- ❑ Cytomegalovirus
- ❑ HIV
- ❑ Kidney Disease or Stones
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Seizure Disorder
- ❑ TB/Tuberculosis
- ❑ Toxoplasmosis
- ❑ Thyroid Disease
- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ HPV (warts, Human Papillomavirus)
- ❑ Herpes
- ❑ Cancer (Type & Treatment)

_____

Past Surgical History: (example: Tonsils, appendectomy, gallbladder)

Surgery	Date

Turn Over



Sunshine FAMILY CARE

Date Form Completed _____

Social History

1.) Spiritual and/or Religious Preference: ❑ _____	**2.) Education** ❑ Highest Grade Completed _____ ❑ High School/GED ❑ College – 2yrs ❑ College – 4yrs ❑ Post-Graduate	**3.) What do you do for a living or what is your Occupation?** ❑ _____ Satisfied with occupation ❑ Yes ❑ No	**4.) Number of Children** ❑ # _____
5.) Who Lives in your current household? ❑ Self ❑ Others List: _____ _____	**7.) Do you feel safe in your living situation?** ❑ Yes ❑ No If No, what makes it unsafe? _____	**8.) Has anyone hit, kicked, pushed or verbally intimidated you?** ❑ Yes ❑ No	**9.) Do you have any current home, work, social or financial stressors affecting your life and well-being?** ❑ No ❑ Yes, explain _____ _____ _____
10.) How many hours of sleep do you get in a 24-hour period? ☐ _____	**11.) Hobbies/recreation** ☐ _____ _____ _____ _____ _____	**12.) Exercise** ☐ None ☐ Types and frequency _____ _____	**13.) Date of last dental exam** _____
14.) Date of last eye exam _____	**15.) Nutrition** **Are you happy with your current weight?** ❑ Yes ❑ No **Are you on a special diet?** ❑ No ❑ Yes, what Kind and why _____ _____	**16.) Do you eat 1-2 servings of fruit and 3-6 servings of vegetable each day?** ❑ No ❑ Yes	**17.) How would you rate your overall nutrition?** ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Terrible

Sunshine FAMILY CARE

Date Form Completed _____

Tobacco/Alcohol/Caffeine/Drugs

1.) Do you use Tobacco Products?

❑ Past User Quit Date _____

❑ Current User

TYPE

❑ Cigarettes # per day_____

❑ Cigars # per day _____

❑ Vaps, hookah # per day _____

❑ Chewing tobacco, snuff, dips # per day___

❑ Marijuana amount per day _____

2.) Do you use alcohol?

❑ No

❑ Yes, see below

Frequency?

❑ Daily

❑ Social

❑ Rare

❑ Binge

Type of alcohol

❑ _____

❑ # per day _____

❑ # per week _____

❑ # per month _____

3.) Do you consume Caffeine?

❑ No

❑ Yes, see below

Type of Caffeine

❑ Coffee, # cups per day ___

❑ Tea, # cups per day ____

❑ Soda, # per day _____

❑ Others _____

4.) Do you use Illicit Drugs?

❑ No

❑ Previous History

❑ Yes, current, see below

Type

❑ Cocaine (Blow, Bump, Dust, Snow, etc.)

❑ Heroin (Smack, Horse, Hero, Brown, etc.)

❑ Methamphetamine (Speed, Crank, Chalk, Cookies, No Doze, etc.)

❑ Prescription Opioids or others

❑ Bath Salts

❑ Barbiturates (Dolls, tooties, jackets, etc.)

❑ Benzodiazepines (Benzos, Downers, Poles, Tranks, etc.)

❑ Others _____

5.) Gynecologic/Obstetric History

❑ Date of Last menstrual cycle: _____ Age menstruation started _____ Age of menopause _____

Problems with menstrual cycle

❑ No problems with menstrual cycle

❑ Irregular

❑ Painful

❑ Heavy bleeding

❑ No Menses

❑ Other _____

Number of Pregnancies _____ **Number of Miscarriages** _____ **Number of Abortions** _____

Current Birth control method _____ **Date of last pap smear** _____

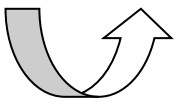
History of abnormal Pap

❑ No

❑ Yes, abnormalities _____

Last Mammogram Date: _____ ☐ Normal ☐ Abnormal

Turn Over



Sunshine FAMILY CARE

Date Form Completed _____

Family Medical History

Father: Living/Deceased Age _____ Cause of Death _____

Brothers: # Alive ___ # Deceased _____ Age ____ Cause of death _____

Mother: Living/Deceased Age _____ Cause of Death _____

Sisters: # Alive ____ # Deceased _____ Age ____ Cause of death _____

1.) Please mark any of the following for family members. (MGM-Mothers Mother, MGF-Mothers Father, PGM-Fathers Mother, PGF-Fathers Father)

❑ High Blood Pressure Who _____

❑ Diabetes Who _____

❑ Mental Illness Type _____ Who _____

❑ Glaucoma Who _____

❑ Osteoporosis Who _____

❑ Heart Disease Type _____ Who _____

❑ Stroke Who _____

❑ Bleeding Disorder Type _____ Who _____

❑ Alcoholism Who _____

❑ Thyroid Disease Who _____

❑ Cancer Type _____ Who _____

❑ Cancer Type _____ Who _____

❑ Others Who _____

Signature: _____ **Date:** _____

(Patient, Parent, or legally Authorized Individual)

Relationship to the Patient: _____

Sunshine FAMILY CARE

Date Form Completed _____

Financial Agreement/Office Policies/Notice of Privacy Practices/Consent for Treatment

Patient Name:_____ Date: _____

I have completed this form accurately to the best of my knowledge and certify that I am the above-named patient or the duly authorized general agent of the above-named patient, authorized to furnish the information requested, and seek and authorize health services. I hereby give my consent and authorize Sunshine Family Care to treat any medical health condition providing that the care provider has explained my condition to me, the treatment procedures, and alternative methods of treating my condition and the care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should,during treatment, a condition be discovered which was not known previously.

I understand that Sunshine Family Care operates a primary care practice that integrates case management health services, which means case management health staff are part of my medical team and experience.

I have carefully read and fully understand this Informed Consent Form and all my questions have beenadequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all following medical health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available forthose who qualify, including a sliding scale fee program.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurancesubmissions.
- I authorize release of all information necessary to secure payments of benefits.
- I consent to Sunshine Family Care sending me one or more messages per day related to my health care. I understanddata usage costs may apply based on my mobile carrier plan.
- I understand that Sunshine Family Care may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have received a copy of Sunshine's Notice of PrivacyPractices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature:_____ Date: _____

Legally authorized representative if not patient: _____ Date: _____

Relationship to Patient: _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences,compliance with law and regulation, and patient education.