

## ADULT PATIENT REGISTRATION AND CONSENT FORM

Today's date: \_\_\_\_\_ PCP: \_\_\_\_\_

### PATIENT INFORMATION

Patient's last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Marital status (circle one)  
Single / Mar / Div / Sep / Wid

Need Translator?  Yes  No If Yes, What language? \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Email address: \_\_\_\_\_@\_\_\_\_\_ Home phone #: (\_\_\_\_) \_\_\_\_\_ Cellular phone #: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
CA

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone #: (\_\_\_\_) \_\_\_\_\_

Veteran:  Yes  No  Migrant  Seasonal Worker  
Ethnicity: (select only one)  Hispanic  Non-Hispanic  
Race: (select one or more)  White  Black / African American  Asian  Pacific Islander  American Indian / Alaska Native  Native Hawaiian  Other

Country of Birth:  US  Other: \_\_\_\_\_ Status at arrival:  Refugee  Asylee  Other About how many years have you lived in the US? \_\_\_\_\_

Income: list immediate family members living in household (spouse & children)	Relationship	Age	Gross Monthly Income	Total Persons
	Self		\$	Total Gross Inc. \$
			\$	
			\$	
			\$	
			\$	

### INSURANCE INFORMATION

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Address (if different): \_\_\_\_\_ Home phone #: (\_\_\_\_) \_\_\_\_\_

Is this patient covered by insurance?  Yes  No

Please indicate primary insurance  Medi-Cal  Medicare  HMO  Other

Medi-Cal ID Number: \_\_\_\_\_ Medicare ID Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Co-payment: \$ \_\_\_\_\_

### IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home / Cell phone #:	Work / Cell phone #:
1) _____	_____	(____) _____	(____) _____
2) _____	_____	(____) _____	(____) _____

I, \_\_\_\_\_, request & give my permission to La Maestra Community Health Centers and its assigned physicians & auxiliary personnel to render such treatment necessary as determined by my condition. I understand auxiliary personnel include Nurse Practitioner, Nurse, & Medical Assistant.

It is further understood that if I refuse any treatment suggested by La Maestra Community Health Centers, I automatically release them from responsibility for damages which may occur because of my refusal. I understand further that it is my responsibility to follow the treatment plan prescribed by the physician. I realize my refusal will be documented and witnessed by no less than two persons, including the physician in charge.

I have received information about advance directive and I understand that I have the right to formulate advance directives that would be filed in my medical file. I understand that I can change my instruction if I desire in the future.

I would like to receive more information  No, I would not like to receive more information

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the clinic indicated on the claim. I understand that I am financially responsible for charges not covered by my insurance or by programs that I am determined to be eligible for. **Initials** \_\_\_\_\_

I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interview with a member of the news medical or by La Maestra Community Health Centers for the promotion of the clinic, its program, services or collaborative. **Initials** \_\_\_\_\_

Payment is expected at time of service.

\_\_\_\_\_  
*Patient/Guardian signature* \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Registered by* \_\_\_\_\_  
*Date*





# Adult History

## I. PAST MEDICAL HISTORY: Check (√) all conditions that you have or have had.

- |  |   |  |   |  |
|--|---|--|---|--|
| <input type="checkbox"/> AIDS              | <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Prostate Disease    |
| <input type="checkbox"/> Alcoholism        | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Gout                | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Cataract           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Measles            | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Allergy           | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Problem     |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pneumonia          |  |
| <input type="checkbox"/> Breast Lump       | <input type="checkbox"/> Epilepsy / Seizure | <input type="checkbox"/> Joint Disease       | <input type="checkbox"/> Polio              |  |

## II. GENERAL HEALTH STATUS:

<u>Vaccines</u>	<u>Date Last Given</u>	<u>Medications</u>	<u>Allergies</u> (Food/Medicine/Weather)	<u>Surgery/Hospitalization</u> (Type/When/Where)
<input type="checkbox"/> Tetanus/Diphtheria	_____	1. _____	1. _____	1. _____
<input type="checkbox"/> MMR	_____	2. _____	2. _____	2. _____
<input type="checkbox"/> Hepatitis	_____	3. _____		3. _____
<input type="checkbox"/> Pneumonia	_____	4. _____	PPD: <input type="checkbox"/> Yes <input type="checkbox"/> No	4. _____
<input type="checkbox"/> Flu Vaccine	_____	5. _____	Result: <input type="checkbox"/> + <input type="checkbox"/> -	

## III. SOCIAL HISTORY

- |                                     |                                   |   |                                       |
|-------------------------------------|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Employed   | <input type="checkbox"/> Single   | <input type="checkbox"/> Smoking Qty _____    | <input type="checkbox"/> Diet Regimen |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> Married  | <input type="checkbox"/> Alcohol Qty _____    | <input type="checkbox"/> Exercise     |
| <input type="checkbox"/> Retired    | <input type="checkbox"/> Divorced | <input type="checkbox"/> Coffee/Tea Qty _____ | <input type="checkbox"/> Sleeping     |
| <input type="checkbox"/> Housewife  | <input type="checkbox"/> Widowed  | <input type="checkbox"/> Drugs Qty _____      | <input type="checkbox"/> Accidents    |

## IV. FAMILY HISTORY: Check (√) if your blood relatives have any of the following

Relation	Age	Health Status	Age at Death	Cause of Death	Disease	Relationship to You
Father					Arthritis/Gout	
Mother					Asthma/Allergy/Hay Fever	
Brothers					Cancer	
					Diabetes	
					Heart Disease/Stroke	
Sisters					High Blood Pressure	
					Kidney/Liver/Stomach	
					Others	

## V. REVIEW OF SYSTEMS:

- |                |   |             |  |             |  |               |  |
|----------------|---|-------------|--|-------------|--|---------------|--|
| <b>General</b> | <input type="checkbox"/> Chills               | <b>Resp</b> | <input type="checkbox"/> Persistent Cough        | <b>GI</b>   | <input type="checkbox"/> Poor Appetite         | <b>Neuro</b>  | <input type="checkbox"/> Numbness          |
|                | <input type="checkbox"/> Dizziness            |             | <input type="checkbox"/> Shortness of Breath     |             | <input type="checkbox"/> Difficulty Swallowing |               | <input type="checkbox"/> Weakness          |
|                | <input type="checkbox"/> Fainting             | <b>CV</b>   | <input type="checkbox"/> Chest Pain              |             | <input type="checkbox"/> Indigestion           |               | <input type="checkbox"/> Depression        |
|                | <input type="checkbox"/> Fever                |             | <input type="checkbox"/> High Blood Pressure     |             | <input type="checkbox"/> Nausea/Vomiting       |               | <input type="checkbox"/> Mood Problems     |
|                | <input type="checkbox"/> Loss of Weight       |             | <input type="checkbox"/> Low Blood Pressure      |             | <input type="checkbox"/> Vomiting Blood        |               | <input type="checkbox"/> Forgetfulness     |
| <b>ENT</b>     | <input type="checkbox"/> Headache             |             | <input type="checkbox"/> Rapid Heartbeat         |             | <input type="checkbox"/> Gas                   |               | <input type="checkbox"/> Loss of Sleep     |
|                | <input type="checkbox"/> Vision, Blurred      |             | <input type="checkbox"/> Irregular Heartbeats    |             | <input type="checkbox"/> Stomach Pain          |               | <input type="checkbox"/> Nervousness       |
|                | <input type="checkbox"/> Painful Ears         |             | <input type="checkbox"/> Swelling of Ankles      |             | <input type="checkbox"/> Diarrhea              | <b>Female</b> | <input type="checkbox"/> Hot Flashes       |
|                | <input type="checkbox"/> Double Vision, Halos |             | <input type="checkbox"/> Sweat                   |             | <input type="checkbox"/> Constipation          |               | <input type="checkbox"/> Vaginal Discharge |
|                | <input type="checkbox"/> Ear Discharge        | <b>Skin</b> | <input type="checkbox"/> Itching/Rash            |             | <input type="checkbox"/> Hemorrhoids           |               | <input type="checkbox"/> Breast Pain       |
|                | <input type="checkbox"/> Hoarseness           |             | <input type="checkbox"/> Change in Moles         |             | <input type="checkbox"/> Rectal Bleeding       |               | <input type="checkbox"/> Breast Lump       |
|                | <input type="checkbox"/> Hearing loss         | <b>GUT</b>  | <input type="checkbox"/> Lack of Bladder Control | <b>Male</b> | <input type="checkbox"/> Erection Problem      |               | <input type="checkbox"/> Nipple Discharge  |
|                | <input type="checkbox"/> Ringing in Ears      |             | <input type="checkbox"/> Frequent Urination      |             | <input type="checkbox"/> Penile Problems       |               | <input type="checkbox"/> Menstrual Prob.   |
|                | <input type="checkbox"/> Sinus Problems       |             | <input type="checkbox"/> Blood in Urine          | <b>MSS</b>  | <input type="checkbox"/> Joints Problems       |               | <input type="checkbox"/> Mamm ( / / )      |
|                | <input type="checkbox"/> Nosebleeds           |             | <input type="checkbox"/> Painful Urination       |             | <input type="checkbox"/> Muscle Pain           |               | <input type="checkbox"/> PAP ( / / )       |

\_\_\_\_\_  
Patient's Signature:

\_\_\_\_\_  
PCP Signature:

\_\_\_\_\_  
Date:



# Historia Adulto

## I. HISTORIA MÉDICA:

Marque (✓) todas las condiciones que tiene o ha tenido.

- |  |   |   |  |   |
|--|---|---|--|---|
| <input type="checkbox"/> SIDA                  | <input type="checkbox"/> Bronquitis                   | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Enfermedad del Riñón        | <input type="checkbox"/> Enfermedad de Próstata   |
| <input type="checkbox"/> Alcoholismo           | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Gota                       | <input type="checkbox"/> Enfermedad del Hígado       | <input type="checkbox"/> Problemas Psiquiátricos  |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Catarata                     | <input type="checkbox"/> Enfermedades Cardíacas     | <input type="checkbox"/> Sarampión                   | <input type="checkbox"/> Derrame Cerebral         |
| <input type="checkbox"/> Alergias              | <input type="checkbox"/> Varicela                     | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Migrañas, Dolores de Cabeza | <input type="checkbox"/> Problemas del Estómago   |
| <input type="checkbox"/> Artritis              | <input type="checkbox"/> Depresión                    | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Paperas                     | <input type="checkbox"/> Problemas de la Tiroides |
| <input type="checkbox"/> Asma                  | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Presion Alta               | <input type="checkbox"/> Marcapasos                  | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Trastorno Hemorrágico | <input type="checkbox"/> Enfisema                     | <input type="checkbox"/> Colesterol Alto            | <input type="checkbox"/> Neumonía                    |   |
| <input type="checkbox"/> Masa de mama          | <input type="checkbox"/> Epilepsia / Desvanecimientos | <input type="checkbox"/> Desorden de Articulaciones | <input type="checkbox"/> Polio                       |   |

## II. HISTORIA MÉDICA GENERAL:

<u>Vacunas</u>	<u>Fecha de Ultimas</u>	<u>Medicamentos</u>	<u>Alergias</u> (Comida/Medicamentos/Ambiente)	<u>Cirugía/Hospitalización</u> (Tipo/Cuándo/Dónde)
<input type="checkbox"/> Difteria/Tétano	_____	1. _____	1. _____	1. _____
<input type="checkbox"/> Sarampión, Paperas, Rubeola	_____	2. _____	2. _____	2. _____
<input type="checkbox"/> Hepatitis	_____	3. _____		3. _____
<input type="checkbox"/> Neumonía	_____	4. _____	Tuberculosis: <input type="checkbox"/> Sí <input type="checkbox"/> No	4. _____
<input type="checkbox"/> Vacuna contra la gripe	_____	5. _____	Resultado: <input type="checkbox"/> + <input type="checkbox"/> -	

## III. HISTORIA SOCIAL

- |                                      |                                     |                                  |                |                                     |
|--------------------------------------|-------------------------------------|----------------------------------|----------------|-------------------------------------|
| <input type="checkbox"/> Empleado    | <input type="checkbox"/> Soltero    | <input type="checkbox"/> Fumar   | Cantidad _____ | <input type="checkbox"/> Dieta      |
| <input type="checkbox"/> Desempleado | <input type="checkbox"/> Casado     | <input type="checkbox"/> Alcohol | Cantidad _____ | <input type="checkbox"/> Ejercicio  |
| <input type="checkbox"/> Retirado    | <input type="checkbox"/> Divorciado | <input type="checkbox"/> Café/Té | Cantidad _____ | <input type="checkbox"/> Dormir     |
| <input type="checkbox"/> Ama de Casa | <input type="checkbox"/> Viudo      | <input type="checkbox"/> Drogas  | Cantidad _____ | <input type="checkbox"/> Accidentes |

## IV. HISTORIA FAMILIAR: Marque (✓) si algún familiar padece lo siguiente.

Relación	Edad	Estado de Salud	Edad de Fallecimiento	Causa de Fallecimiento	Dolencia / Enfermedad	Relacion a Ti
Padre					Artritis/Gota	
Madre					Asma/Alergia/Fiebre	
Hermanos					Cáncer	
					Diabetes	
					Cardiopatía/Derrame Cerebral	
Hermanas					Hipertensión Arterial	
					Riñón/Hígado/Estómago	
					Otro	

## V. REVISIÓN DE SISTEMAS:

- |                |   |                     |  |                  |  |                 |   |
|----------------|---|---------------------|--|------------------|--|-----------------|---|
| <b>General</b> | <input type="checkbox"/> Escalofríos            | <b>Respiratorio</b> | <input type="checkbox"/> Tos Persistente               | <b>GI</b>        | <input type="checkbox"/> Perdida de Apetito      | <b>Neuro</b>    | <input type="checkbox"/> Entumecimiento           |
|                | <input type="checkbox"/> Mareos                 |                     | <input type="checkbox"/> Fatiga                        |                  | <input type="checkbox"/> Dificultad en Tragar    |                 | <input type="checkbox"/> Debilidad                |
|                | <input type="checkbox"/> Desmayos               | <b>CV</b>           | <input type="checkbox"/> Dolor de Pecho                |                  | <input type="checkbox"/> Indigestion             |                 | <input type="checkbox"/> Depresión                |
|                | <input type="checkbox"/> Fiebre                 |                     | <input type="checkbox"/> Hipertensión Arterial         |                  | <input type="checkbox"/> Vómito Sangre           |                 | <input type="checkbox"/> Cambios de Humor         |
|                | <input type="checkbox"/> Perdida de Peso        |                     | <input type="checkbox"/> Presion Arterial Baja         |                  | <input type="checkbox"/> Gas                     |                 | <input type="checkbox"/> Perdida de Memoria       |
| <b>ENT</b>     | <input type="checkbox"/> Dolor de Cabeza        |                     | <input type="checkbox"/> Taquicardias                  |                  | <input type="checkbox"/> Dolor Estómago          |                 | <input type="checkbox"/> Perdida de Sueño         |
|                | <input type="checkbox"/> Visión Borrosa         |                     | <input type="checkbox"/> Latidos del Corazón Irregular |                  | <input type="checkbox"/> Diarrea                 |                 | <input type="checkbox"/> Ansiedad                 |
|                | <input type="checkbox"/> Dolor de Oído          |                     | <input type="checkbox"/> Hinchazón de los Tobillos     |                  | <input type="checkbox"/> Estreñimiento           | <b>Femenino</b> | <input type="checkbox"/> Calores                  |
|                | <input type="checkbox"/> Doble Visión, Halos    |                     | <input type="checkbox"/> Sudoroso                      |                  | <input type="checkbox"/> Hemorroides             |                 | <input type="checkbox"/> Secreción Vaginal        |
|                | <input type="checkbox"/> Secreción de Oído      | <b>Piel</b>         | <input type="checkbox"/> Rosaduras/Comezón             |                  | <input type="checkbox"/> Sangrado Rectal         |                 | <input type="checkbox"/> Dolor de Pecho           |
|                | <input type="checkbox"/> Ronquera               |                     | <input type="checkbox"/> Cambios de Lunares            | <b>Masculino</b> | <input type="checkbox"/> Problema Erección       |                 | <input type="checkbox"/> Masa de Mama             |
|                | <input type="checkbox"/> Perdida de Audición    | <b>GUT</b>          | <input type="checkbox"/> Incontinencia                 |                  | <input type="checkbox"/> Impotencia              |                 | <input type="checkbox"/> Desecho de Mama          |
|                | <input type="checkbox"/> Zumbido de Oído        |                     | <input type="checkbox"/> Orina con Frecuencia          | <b>MSS</b>       | <input type="checkbox"/> Problemas de Coyonturas |                 | <input type="checkbox"/> Problema Ciclo Menstrual |
|                | <input type="checkbox"/> Problema de Seno Nasal |                     | <input type="checkbox"/> Sangre en Orina               |                  | <input type="checkbox"/> Dolores Musculares      |                 | <input type="checkbox"/> Mamografía ( / / )       |
|                | <input type="checkbox"/> Hemorragia Nasal       |                     | <input type="checkbox"/> Dolor al Orinar               |                  |  |                 | <input type="checkbox"/> Papanicolau ( / / )      |

Firma del Paciente: \_\_\_\_\_

Firma de PCP: \_\_\_\_\_

Fecha: \_\_\_\_\_



## Notice of Privacy Practices

### Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of La Maestra Community Health Centers. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting La Maestra Community Health Centers at **(619) 280-4213**.

If you have any questions about our *Notice of Privacy Practices*, please contact:

The Privacy officer at **(619) 578-2584**

I acknowledge receipt of a copy of the *Notice of Privacy Practices* of La Maestra Community Health Centers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(*patient/parent/conservator/guardian*)

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### Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_



## Notificación de los Procedimientos de Privacidad

### Recibo de Enterado

Al firmar este recibo usted afirma haber recibido copia de la *Notificación de los Procedimientos de Privacidad*. Nuestra *Notificación de Procedimientos de Privacidad* le da información de cómo podemos utilizar y dar información de su salud, información que está protegida. Le recomendamos que lea pro completo este aviso.

Nuestra *Notificación de los Procedimientos de Privacidad* esta sujeta a cambios. Si esto ocurre, usted puede obtener una copia actualizada llamando al siguiente número de teléfono de la clínica médica **(619) 280-4213**.

Si usted tiene alguna pregunta en relación a esta notificación de los procedimientos de privacidad, por favor comuníquese al **(619) 578-2584**.

Me doy por informado al recibir esta copia de la *Notificación de los Procedimientos de Privacidad* de La Maestra Community Health Centers.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente/Padre/Tutor)

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### Inhabilidad para Obtener esta Notificación

Para completar si no es posible de obtener la firma individual. Si no es posible obtener la firma describa el esfuerzo hecho para informar de este aviso y la razón por la cual la firma no fue obtenida.

Firma del representante del proveedor: \_\_\_\_\_ Fecha: \_\_\_\_\_



## **Notice of Advance Health Care Directive** **(California Probate Code Section 4701 Acknowledgement of Receipt)**

### **Acknowledgement of Receipt**

By signing this form, you acknowledge receipt of the notice of Advance Directive of La Maestra Community Health Centers. This information is about your decision in advance of what medical treatments you want to receive in the event you become physically or mentally unable to communicate your wishes.

If you have any questions or need additional information about our notice of Advance Directive, please contact our administration office at **(619) 578-2584**.

I acknowledge receipt of the Notice of Advance Directive of La Maestra Community Health Centers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*(patient/parent/conservator/guardian)*

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### **Inability to Obtain Acknowledgement**

To be completed only if no signature is obtain. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was obtained.

Signature of provider representative: \_\_\_\_\_ Date: \_\_\_\_\_



## **Notificación de Instrucciones Anticipadas** **(Código 4701)**

### **Recibo de Enterado**

Al firmar este recibo usted afirma haber recibido copia de la *Notificación de Instrucciones Anticipadas*, esta información es referente a su decisión anticipada de que los tratamientos médicos que usted desea recibir en caso que no pueda comunicarse o se encuentra demasiado enfermo física o mentalmente para hacer sus propias decisiones.

Si usted tiene alguna pregunta en relación a esta notificación de los procedimientos de privacidad, por favor comuníquese al **(619) 578-2584**.

Me doy por informado al recibir esta notificación de La Maestra Community Health Centers.

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Paciente/Padre/Tutor)

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### **Inhabilidad para Obtener esta Notificación**

Para completar si no es posible de obtener la firma individual. Si no es posible obtener la firma describa el esfuerzo hecho para informar de este aviso y la razón por la cual la firma no fue obtenida.

Firma del representante del proveedor: \_\_\_\_\_ Fecha: \_\_\_\_\_