Chambers Community Health Centers, Inc.

"What You Need - Where You Are"

PATIENT INFORMATION / CONSENT FORM

Patient Name: _____ **Date of Birth:** _____
Last, First Middle Initial

Mailing Address: _____
City State Zip Code

Home#: _____ **Cell #:** _____ **Work #:** _____

Email: _____ **Social Security #:**_____--_____--_____

Responsible Party: _____ **Relationship:** _____ **Phone#:**_____

Emergency Contact: _____ **Relationship**: _____ **Phone #**: _____

Sex: ☐ Female ☐ Male ☐ Transgender

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Household Income: ☐ Under $20,000 ☐ $20,000 -- $40,000 ☐ $40,000 -- $80,000 ☐ Over $80,000

Disability: Yes☐ No☐ **Veteran:** Yes☐ No☐

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify)_____

Race:
- ☐ White, Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Unreported/Refused to Report

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Refused to Report

Primary Insurance: _____ **ID #**_____ **Group #**_____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Secondary Insurance: _____ **ID #**_____ **Group #**_____

Policy Holder's Name: _____ **Policy Holder's DOB:** _____

Please read and sign the authorization statements below. This is necessary to complete your record.

Authorization of Benefits to Provider: I understand that I am financially responsible for all charges incurred with Bayside Clinic and/or West Chambers Medical Center, herein after referred to as 'Health Center.' I hereby assign and relinquish my interest in and title to my insurance benefits to the Health Center for all medical services rendered. I hereby authorize the Health Center to furnish information to the insurance(s) concerning my illness/accidents. I realize that my records may be electronically transmitted (faxed) may not be received by the intended recipient. Should this occur, I release the Health Center from all liability.

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP): Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. I hereby acknowledge that I have received a copy of the Notice of Privacy Practice for this facility and understand that I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Physician Assistant/Nurse Practitioner Consent: The Health Center has on staff, Physician Assistants and/or Nurse Practitioners, to deliver medical care. A Physician Assistant and/or Nurse Practitioner is a graduate of a certified training program and is licensed by a State Board. Under the supervision of a physician, a Physician Assistant and/or Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. 'Supervision' does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. I have read the above, and by signing below hereby consent, to the services of a Physician Assistant and/or Nurse Practitioner for my healthcare needs. I understand that at any time I can refuse to see the Physician Assistant and/or Nurse Practitioner and request to see a physician.

Permit for Diagnosis and Treatment: I understand that presentation to the clinic is indicated by my condition or medical need. I voluntarily authorize and consent to the customary examinations, test, and procedures performed on patients in my condition and to routine medical treatment ordered by my physician.

_____ _____ **Date**_____ /_____ /20_____

Signature of Patient or Authorized Representative **Relationship to Patient**

Bayside Clinic
Anahuac, TX 7751
409-267-4126

PATIENT HISTORY SHEET

www.chambershealth.org

West Chambers Medical Center
Mt Belvieu, TX 77580
281-576-0670

Patient Name **DOB** **ALLERGIES**

Have you ever been hospitalized for an illness or had an operation? Yes No
If so, give age and reason for hospitalization or operation:

Age _____ Reason _____
Age _____ Reason _____
Age _____ Reason _____

Have you had any serious injuries? Yes No

Age _____Reason_____
Age _____ Reason _____

Do you take medications regularly? Yes No

Medication	How long	Reason
_____	_____	_____
_____	_____	_____

Are your immunization up to date? Yes No Dates of your immunizations: _____ (Patients under 18 yrs please bring shot record)

Please mark if you ever had any of the following?

_____ Acne/Skin Problems	_____ Diabetes	_____ Pregnancy Problems
_____ Asthma/Lung Disease	_____ Stomach/Intestinal Problems	_____ Housing Issues
_____ Bladder Infection	_____ Heart Disease/High Blood Pressure	_____ Gang-Related Issues
_____ Tuberculosis	_____ Thyroid	_____ Legal Trouble
_____ Infectious/Liver Disease	_____ Cancer	_____ Fad Diet
_____ Hepatitis	_____ Scoliosis/Back Problems	_____ Alcohol User
_____ STD's	_____ Depression/Mood Swings	_____ Drug User
_____ Headaches	_____ Attempted Suicide/	_____ Smoker
_____ Seizures/Epilepsy	_____ Problem Sleeping	_____ Physical/Emotional Abuse
_____ Vision	_____ Low Self-Esteem	_____ Learning Problems
_____ Hearing Problems	_____ Family Stressors	_____ Blood Transfusions/Products
_____ Sickle Cell Anemia/Trait	_____ Financial Problems	_____ Occupational Hazards

Do you have specific health concerns?

_____

Family History (Please check if anyone in your family has had or currently diagnosed with any of the following)

_____ Cancer	_____ Diabetes	_____Learning Problems
_____ Heart Attack (<55)	_____ Drug Abuse	_____ Tuberculosis
_____ High Blood Pressure	_____ Mental Illness	_____ Stroke

Did your mother/grandmother take DES during Pregnancy (Drug used to prevent miscarriage) during pregnancy? Yes No
Are there any problems at home you would like to discuss with your provider? Yes No
Are you concerned about your safety at home or in the community? Yes No
How do you spend you time (TV, Hobbies)? _____
Would you like information on sexually transmitted diseases? Yes No
Would you like referral on any of the above issues? Yes No

Patient Signature _____ **Date** _____ **Providers Initials & Date** _____

Updates/No Changes

1. _____ _____ 2. _____ _____ 3. _____ _____
Patient Initial Date Patient Initial Date Patient Initial Date

1. _____ _____ 2. _____ _____ 3. _____ _____
Provider Initial Date Provider Initial Date Provider Initial Date

Comments:

_____

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