SAMUEL DIXON FAMILY HEALTH CENTER, INC.
PATIENT REGISTRATION FORM

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

NAME: _____ **Email Address:** _____

ADDRESS: _____
City State Zip

1. **Home Phone #:** _____ **Cellular Phone #:** _____
2. D.O.B.: _____ Birth Gender: _____ SSN #: _____
3. Single _____ Married _____ Divorced _____ Widowed _____ Other _____
4. Emergency Contact: Name: _____ Phone: _____ Relation: _____
5. Gender of the Head of your Household: Male ___ Female ___ Are you a US Veteran? Yes___ No___
6. What is the Head of your Household's Occupation: _____ Your Occupation: _____
7. Are you a Migrant Worker? Yes___ No___ Seasonal Worker? 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 Center 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.

_____ _____
Applicant's Signature *Date*

Revised 9/10/2020

OFFICE USE ONLY: Date Reviewed: _____ Staff Signature: _____

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	Newhall	Canyon Country
30257 San Martinez Road	23772 Newhall Ave.	27225 Camp Plenty Road, Suite 2
Val Verde, CA 91384	Newhall, CA 91321	Canyon Country, CA 91351
Tel: 661-257-4008	Tel: 661-291-1777	Tel: 661-424-1220
Fax 661-257-3056	Fax: 661-255-1208	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: _____

Revised 04/10

SAMUEL DIXON FAMILY HEALTH CENTER
PERSONAL MEDICAL HISTORY
(Please complete both pages as accurately as possible)

NAME:_____ _____ CHART NUMBER:_____
Today's Date:_____Age:_____Sex:_____Height:_____DOB:_____
Marital Status: ( )Married ( )Single ( )Divorced ( )Widowed Occupation:_____

PLEASE LIST YOUR IMMEDIATE COMPLAINTS:	

ALLERGIES: ( ) NONE ( ) YES, LIST INCLUDING MEDICATIONS, FOODS, POLLENS	

CURRENT MEDICATIONS & DOSE: ( ) NONE INCLUDE OVER THE COUNTER MEDICATIONS AND VITAMINS		
1-	5-	9-
2-	6-	10-
3-	7-	11-
4-	8-	12-

PAST ILLNESSES -	**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**
Measles				Mumps				Migraine Headaches			
Rubella				Rheumatic Fever				Chicken Pox			
Monucleosis				Meningitis				Hernia			
Pneumonia				Diabetes				Syphilis			
Emphysema				Thyroid Disease				Other Venereal Diseases			
Asthma				Arthritis				Broken Bones			
Bronchitis				Gout				Nervous Breakdown			
Kidney Stone				Cancer (type)				Suicide Attempt			
Kidney Infection				Colitis				Depression (requiring meds)			
Ulcers				Diverticulitis				Drug/Alcohol Abuse			
Hepatitis				Irritable/Spastic Bowel				Major head Injury			
Liver Disease				Heart Attack				Transfusions			
Gallbladder Disease				Heart Murmur				Other Major Illnesses/Injuries			
AIDS				Stroke							
Bleeding Tendencies				High Blood Pressure							
Tuberculosis				Heart Problem							
Positive TB Test				Epilepsy/Seizures							
MALES ONLY -	**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**
Enlarged Prostate				Prostate Infection				Epididymitis			
Testicle Problem				Urin Ifections				Other -			
FEMALES ONLY	**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**
Abnormal Pap Smear				Benign Breast Lump				Ovarian Cysts			
Uterine Fibroids				Pelvic Infection				Urine Infections			
PMS				Painful Periods				Contraception (type) -			
Age at First Period -				Periods Regular?				Date of Last Period -			
Number of Pregnancies -				Number of Deliveries -				Miscarriages/Abortions # -			

PAST SURGERIES (Type/Year): ( ) NONE		
1-	4-	7-
2-	5-	8-
3-	6-	9-

PAST EXAMS (Dates	**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**		**YES**	**NO**	**Unk**
Physical				Stool Hematest				Mammogram			
Pap Smear				Sigmoidoscopy				TB Test			
Other Tests -											

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		
Trouble sleeping			Dizziness			stopping urine flow		
Suicidal thoughts			Numbness/tingling			**OTHER PROBLEMS/CONCERNS -**		
Depression			Balance problems					
Family problems			**BREASTS -**	**YES**	**NO**			
Drug problems			Lumps/pain/discharge					