Community Care Center for Forsyth County Inc.

Patient Information

First Name	Middle Name	Last Name

Address	Apt#	City	Zip Code

Date of Birth ____/____/_____ ____**Male** ____**Female**
Month Day Year

Social Security or ITN #_____ **None** □

Home Ph#	Cell Ph#	Wk Ph#
Email address:	**Emergency Contact Name:**	**Emergency Ph #1**
Employer:	**Relationship:**	**Emergency Ph #2**
Ethnic Group (please choose one): ____Hispanic ____Non Hispanic	**Race (please choose one):** _____AA/Black _____Asian _____ Indian _____ White _____ Other	**Education information (please choose one):** ____None ____Middle ____High ____Assoc. Degree ____BA/BS ____Other
Employment Information (please choose one): ____Employed ____Self Employed ____Unemployed ____Student ____Homemaker ____Minor	**What County Do you Live in? (please choose one)** ____Forsyth Other: ____Stokes ____Davie _____	**How did you hear about us? (please choose one)** ____Family ____Yellow Pages ____Friend ____Radio ____Hospital ____TV ____Internet ____Other:_____

Patient Consent (Read Carefully)

I understand that Community Care Center ("CCC") may not be able to meet all of my health care needs. Doctors are available at CCC only during clinic hours. No providers are on call other hours. I know I must seek care somewhere else in an emergency or for care that cannot wait until clinic is open.

I give my permission to be examined and treated by clinic doctors. I understand that students and other non-licensed healthcare providers may be assisting the providers.

I understand that some services could be cancelled or need to be rescheduled without advance notice. I understand that clinic staff may need to reach me by telephone or mail for medical reasons. I consent to the use and disclosure of my protected health information for treatment purposes. When a referral is made for care outside of CCC, I understand that these services may not be free. I understand that CCC will make a referral on my behalf to HealthCare Access or another source of their choosing. I also understand that it is my responsibility to follow-up with a provider at Community Care Center in a timely manner if I haven't heard from anyone about my referral. CCC has no control over scheduling of care in other facilities. If the wait seems excessive, I understand that I have the option to request a copy of my referral form and choose another provider/facility of my choice that may or may not charge me.

I further understand that I must meet eligibility requirements of CCC in order to be a patient. I understand that if I provide false or incomplete information or fail to update my information, I may be terminated as a patient. I understand that it is my responsibility to advise staff if my family income increases or anyone in the family becomes eligible for or receives health insurance, Medicare, Medicaid or VA benefits. Please note that by signing below you acknowledge that rude or abusive conduct toward staff or volunteers may be reason for termination as a patient of Community Care Center for Forsyth, Inc.

*******Is this patient a minor? _____ No _____Yes If yes, Parent must sign.

_____ _____ _____
Patient or Parent Signature Relationship Today's Date

We are pleased to advise you....

Community Care Center For Forsyth County Inc. was recently approved for the Federal Tort Claims Act (FTCA) Program! We are one of only six programs in North Carolina and 78 in the United States who have qualified.

Because Community Care Center has demonstrated it's commitment to quality patient care services by ensuring quality management programs are in place and that all volunteer health care professionals seeking FTCA coverage undergo comprehensive evaluation and review, we have been notified by the Department of Health & Human Services that we are approved for sponsorship of qualifying volunteer health care professionals. Congress enacted the FTCA program in 2004 to provide medical malpractice coverage for volunteer free clinic health care professionals who meet certain standards.

As a part of this program, we are required to provide you, our patient, with the following notice and secure your signature to acknowledge that you have received the notice.

Notice to Patients

As described certain free clinic health care professionals providing health care services to patients at ***Community Care Center For Forsyth County Inc.*** *may be covered by this Federal law.*

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

This notice is to be provided to the individual patient before health care services are provided, except in emergency cases when notice may be provided as soon after the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her care under State law.

Acknowledged: _____
Patient name, printed legibly

_____
Patient signature

_____
Parent/legal guardian or legal representative

Patient Health History
Confidential

Patient's name: _____

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail):

_____

_____

Past Medical History: Please check all that apply to you:

- ❑ Asthma/emphysema
- ❑ Cancer
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ Other: _____

Previous Surgeries: Please list past surgeries with approximate date:

_____

_____

Serious Injury: Please describe any serious injuries you have had:

_____

Medications: Please list any medications you are taking with dose and frequency:

Drug	*Dose/Frequency*
_____	_____
_____	_____
_____	_____

Allergies: please list any allergies that you have _____

Social History:

Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____

Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____

Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____

Are you on a special diet? ❑Yes ❑No If yes, please describe? _____

Family History: Do you know of any immediate relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid

Patient Health History

As you review the following list, please check any problems or conditions that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Ringing in ears
- ❑ None
- ❑ Other: _____

Eyes
- ❑ Blind spots
- ❑ Double/blurred vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Stomach/ abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other: _____
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Female: vaginal discharge
- ❑ Kidney stones

Female: last Pap smear on: _____/_____/_____

Female: last mammogram on: _____/_____/_____
- ❑ Male: prostate disease
- ❑ Painful urination/burning
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention
- ❑ Incontinence
- ❑ Other: _____
- ❑ None

Heart
- ❑ Pain in chest
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other: _____
- ❑ None

Muscles/Joints/Bones
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Loss of consciousness
- ❑ Difficulty speaking
- ❑ Headaches/migraines
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke/mini strokes
- ❑ Tremors
- ❑ Weakness
- ❑ Other: _____
- ❑ None

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Lungs
- ❑ Asthma
- ❑ Blood in cough
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Other: _____
- ❑ None

Endocrinology
- ❑ Intolerance to cold weather
- ❑ Unusual thirst
- ❑ Frequent urination

Sleep
- ❑ Snoring

Do you sleep well? ❑Yes ❑No

COMMUNITY CARE CENTER – Annual Questionnaire

Once a year, all our patients will be ask to complete this form, please help us provide you with the best medical care by answering the questions below.

Name: _____ **Medical Record#:**_____

Date of birth: _____/_____/_____ (Month / Day / Year) **Date:** _____/_____/_____

County of Residence: _____

1. What is your gender?

☐ Male ☐ Female ☐ Transgender

2. Are you Hispanic or Latino?

☐ Yes ☐ No

3. What ethnic group do you consider yourself?

☐ Central American
☐ Dominican
☐ Puerto Rican
☐ Other - *SPECIFY* _____
☐ Cuban
☐ Mexican
☐ South American

4. What is your race?

☐ Black or African American ☐ White ☐ Alaska Native

☐ Native Hawaiian or other Pacific Islander ☐ American Indian ☐ Asian

5. How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?

☐ None ☐ 1 or more

If you are a MALE: How many times in the past year have you had 5 or more drinks containing alcohol in a day?

☐ None ☐ 1 or more

If you are a FEMALE: How many times in the past year have you had 4 or more drinks containing alcohol in a day?

☐ None ☐ 1 or more

MILITARY FAMILY AND DEPLOYMENT

6. Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?

☐ No ☐ Yes, in the Armed Forces ☐ Yes, in the Reserves ☐ Yes, in the National Guard

7. Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard?

☐ No, separated or retired from the Armed Forces or National Guard
☐ Yes, in the Armed Forces
☐ Yes, in the Reserves
☐ Yes, in the National Guard

8. Have you ever been deployed to a combat zone? [CHECK ALL THAT APPLY]

☐ Never deployed
☐ Iraq or Afghanistan (E.G., OEF/OIF/OND)
☐ Persian Gulf (OPERATION DESERT SHIELD/DESERT STORM)
☐ Vietnam/Southeast Asia
☐ Korea
☐ WWII
☐ Deployed to a combat zone not listed above (E.G., BOSNIA/SOMALIA)