Patient Intake Form

(Six pages total.)

DREAM CENTERS WOMEN'S CLINIC

Medical Insurance

Do you have insurance? ◯ No, none ◯ Medicaid/Medicare ◯ Peak Vista ◯ CICP ◯ Other (please name)
If yes, STOP and speak to the front desk personnel.

TODAY'S DATE

Personal Information [Please print and use a blue or black pen to fill out this form.]

First Name | Last Name | Initial | Birth Date

Address | Apartment | Age

City | State | Zip Code

Email Address | Primary Spoken Language | Secondary Spoken Language

Employer | Occupation | Hours Worked Per Week

◯ Part-Time
◯ Full-Time

Work Phone | Home Phone | Cell Phone

Is it safe to reach you here? ◯ Yes ◯ No
May we leave a message? ◯ Yes ◯ No

Is it safe to reach you here? ◯ Yes ◯ No
May we leave a message? ◯ Yes ◯ No

Is it safe to reach you here? ◯ Yes ◯ No
May we leave a message? ◯ Yes ◯ No

CURRENT SOCIAL CONCERNS
A resource advocate may be available in person or by phone. When is a good time to reach you?

◯ AM
◯ PM

CHECK ALL SOCIAL CONCERNS THAT APPLY...

- ◯ Violence in Home
- ◯ Substance Abuse (alcohol, drug, prescription)
- ◯ Emotional Concerns
- ◯ Sexual Abuse
- ◯ Medication Assistance
- ◯ Prenatal Care
- ◯ Education or GED Assistance
- ◯ ESL (English as a Second Language) Information
- ◯ Dental Assistance {Office use only.} Date dental packet given: _____
- ◯ Employment
- ◯ Vision Assistance
- ◯ Parenting Resources
- ◯ Housing or Homelessness
- ◯ Transportation
- ◯ Clothing ◯ Food

Within the past three months, have you worried whether your food would run out before you had the money to buy more?
◯ Yes ◯ No

Within the past three months, did the food you bought run out and you didn't have money to buy more?
◯ Yes ◯ No

OTHER SOCIAL CONCERNS: _____

Treatment and Consent

DREAM CENTERS WOMEN'S CLINIC

1. CONSENT TO CARE AND TREATMENT—I consent to care, treatment, and diagnostic evaluations performed by the health care providers at the Dream Centers Women's Clinic. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

2. HEALTH CARE—I understand that my care, treatment, and diagnostic evaluations will be performed at the direction of my attending physician or health care provider. It is my attending physician or health care provider's responsibility to provide informed consent relating to invasive diagnostic and medical procedures. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made as to outcome of the care provided. I further understand that Dream Centers Women's Clinic provides clinical experiences for students who are interested in studying in health care fields and volunteer health care providers from El Paso County. If I have a concern about having a student observe or participate in my care, I will advise my nurse, physician's assistant (PA), nurse practitioner (NP), or physician.

3. RELATED RELEASE OF INFORMATION—Dream Centers Women's Clinic may release medical and other information about me in accordance with Dream Centers Women's Clinic's privacy practices as described in its Notice of Privacy Practices. I may request a copy of this notice from Dream Centers Women's Clinic at any time.

4. AGREEMENT TO PAY AND GUARANTEE—I understand that my visit is free, but that I may be charged by providers for laboratory and other ancillary services received outside of the Dream Centers Women's Clinic. I may also be responsible for pharmaceuticals obtained from pharmacies outside of Dream Centers Women's Clinic. I understand that my signature indicates agreement with this Treatment and Consent form.

5. PERSONAL VALUABLES—I understand that Dream Centers Women's Clinic will not be responsible for the loss or damage to my property, articles of value, cells phones, or money. Dream Centers Women's Clinic strongly recommends that items of value or money be left at home or given to a family member or bring the items into the examination room with you. Upon leaving the clinic, I will remove all of my property. I understand that property left at Dream Centers Women's Clinic will be kept in a lost and found for safe keeping until I can claim it, or up to 1 month after my visit.

6. IMMUNITY—Medical care or treatment at Dream Centers Women's Clinic may be provided by individuals who are volunteer health care providers. They are legally and professionally licensed and are not employed by Dream Centers Women's Clinic.

7. HIPAA—The Health Insurance Portability and Accountability Act of 1996 Privacy and Security Rules can be found at www.hhs.gov/ocr/privacy. Learn about the rules protection of individually identifiable health information, the rights granted to individuals, enforcement, and how to file a complaint. The Office for Civil Rights enforces the HIPAA Privacy Rule (protects the privacy of individually identifiable health information). The HIPAA Security Rule sets national standards for the security of electronically-protected health information. The confidentiality provisions of the Patient Safety Rule protect identifiable information being used to analyze patient safety events and improve patient safety. What happens at the clinic (and during the phone calls) stays at the clinic. This is a place for everyone to feel safe and secure.

NOTICE—If there is a medical emergency at Dream Centers Women's Clinic, 911 will be called immediately the patient will be transferred to a local hospital.

HIPAA Questionnaire

1. SHARING OF INFORMATION Please list the family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and health care operations). These will be the only people we will be able to speak to or release any information to regarding your account.

Name _____ Phone Number _____

Name _____ Phone Number _____

2. PHONE CALLS Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information. _____

3. CONFIDENTIAL MESSAGES Can confidential messages (i.e., appointment reminders and test results) be left on your telephone answering machine or voice mail? ◯Yes ◯No

4. CORRESPONDENCE Please indicate if we may mail your appointment reminder/recall postcard via the mail or email?

◯Yes ◯No Mailing address where you would like mail sent. _____

◯Yes ◯No Email address where you would like information to be sent. _____

5. CHANGES This form will remain in effect until you make any changes in writing.

Patient Name (Printed) **Patient Signature** **Date**

Comprehensive Medical History

DREAM CENTERS WOMEN'S CLINIC

WHY DID YOU VISIT US IN THE CLINIC TODAY? _____

_____

_____

HEALTH HISTORY

Please check if and when you or a family member ever had...	You (when?)	Family (when?)		You (when?)	Family (when?)		You (when?)	Family (when?)
Addiction/Alcoholism			Digestive Disorders			Migraines		
Allergies			Gallstones			Osteoporosis		
Anemia			Heart Disease			Pneumonia		
Arthritis			Heart Murmur			Seizures		
Asthma			Hepatitis			Skin Disease		
Blood Clot: Leg or Lung			High Cholesterol			STD		
Blood Transfusion			HIV/AIDS			Tuberculosis		
Breathing Problems			Hypertension/HBP			Thyroid Disease		
Cancer			Insomnia			Ulcers		
Colitis			Kidney Disease			Recurrent Urinary Tract Infection		
Diabetes			Kidney Stones			Varicose Veins		

Last colonoscopy? | Abnormal Results? | Last bone density test? | Results?

HEALTH HABITS

Tobacco Packs/Day_____ Years Smoked _____ Quit? ◯ Yes ◯ No Alcohol Drinks/Week _____ Quit? ◯ Yes ◯ No

Drug Use ◯ Yes ◯ No Marijuana Use ◯ Yes ◯ No Do you have any objections to blood transfusions? ◯ Yes ◯ No

Caffeine per Day _____ Sleep Concerns? ◯ Yes ◯ No Stress Concerns? ◯ Yes ◯ No

Weight Concerns? ◯ Yes ◯ No What is your exercise routine? _____

How would you describe your diet? _____

Do you wear a seat belt? ◯ Yes ◯ No

How often do you perform a self-breast exam? _____ When was your last tetanus shot? _____

What is your daily calcium intake (diet and/or supplements)? _____ Daily Vitamin D intake? _____

History of Sexual Abuse? ◯ Yes ◯ No Do you feel safe at home and work? ◯ Yes ◯ No

Any additional information if it would be helpful: _____

_____

_____

Comprehensive Medical History (continued)

DREAM CENTERS WOMEN'S CLINIC

GYNECOLOGICAL HISTORY

Last Pap Smear	Mammogram	Age at 1st Period	1st Day Last Period	How Often is Your Period?	Duration of Period?

PLEASE CHECK AND PUT DATE DOWN FOR (ALL THAT APPLY) IF YOU HAVE EVER HAD...

Yeast Infection		Abnormal Pap Smear		Birth Control Methods	
Trichomonas		Colposcopy		Infertility	
Bacterial Vaginosis (BV)		Cervical Cancer		Sexual Problems: Painful Intercourse	
Genital Lesions		Fibrocystic Breast		Sexual Problems: Lack of Sexual Desire	
Genital Herpes		Breast Biopsy or Surgery *		Endometriosis	
Genital Warts (Condyloma)		Breast Cancer		D & C	
Gonorrhea		Uterine Fibroids		Lapatroscopy	
Chlamydia		Bladder Surgery*		Hysterectomy*	
Syphilis		Pelvic Inflammatory Disease (PID)		HIV	

Did your mother take Diethylstibestrol (DES) when she was pregnant with you? ◯Yes ◯No ◯Unknown

SURGERIES * List surgeries, dates, and relevant comments pertaining to the issue. _____

SEX Age of 1st Intercourse _____
Currently Sexually Active? ◯Yes ◯No

Currently Have Same-Gender Partner(s)? ◯Yes ◯No
In the past year, how many sexual partners have you had?_____
Birth Control Method _____

PREGNANCY HISTORY List all pregnancies, including miscarriages and/or abortions.

Year	Duration (Months/Weeks)	Labor Length	Weight of Baby	Baby Gender	Delivery Type	Complications

PRENATAL VISIT Are you pregnant? ◯Yes ◯No ◯Don't Know Have you received prenatal care? ◯Yes ◯No

ALLERGIES Allergic to any medications? ◯Yes ◯No

Which ones? What is your allergic reaction?

PREFERRED PHARMACY

PRESCRIPTIONS & OVER-THE-COUNTER MEDICATIONS—Please list current prescription and over-the-counter medications including vitamins and supplements. These should be verified by a medical professional at the Women's Clinic.

	Medication	Dose/Frequency	Reason for Taking	Start Date	Prescriber
1					
2					
3					
4					

Patient Survey & Demographic Information

[Please print using a blue or black pen.]

DREAM CENTERS WOMEN'S CLINIC

FIRST NAME _____ LAST NAME _____ TODAY'S DATE _____

Thank you for coming into the Dream Centers Women's Clinic (DC Women's Clinic). We are privileged to serve you today and we thank you for coming in to receive health care. Please take a few minutes to fill out this survey. It will be extremely helpful to us. With this information, we will learn how to better serve you and our community at large. This information helps us figure out exactly who is utilizing our clinic. Answers will not change your access to health care. Answer to the best of your ability. Thank you!

HOW DID YOU HEAR ABOUT THE WOMEN'S CLINIC?
◯ Relative ◯ Friend ◯ Another clinic ◯ DC Women's Clinic patient ◯ Internet ◯ Radio ◯ Brochure ◯ Church ◯ Other ↓

EDUCATION LEVEL
◯ Elementary/ Middle School ◯ Some High School ◯ High School Graduate ◯ Some College ◯ College Graduate ◯ Some Grad School ◯ Graduate Degree ◯ Professional Degree

RACE
◯ American Indian or Alaskan Native ◯ Asian ◯ Black or African American ◯ Hispanic or Latino ◯ Native Hawaiian or Other Pacific Islander ◯ White (Non-Hispanic) ◯ Other ↓

INSURANCE (does not disqualify you from DC Women's Clinic)
◯ Yes, through my employer ◯ Yes, I purchase private insurance ◯ No, I do not have insurance ◯ I am covered by Medicaid ◯ I am covered by Medicare

MILES FROM CLINIC
ZIP CODE _____
◯ 0–1 ◯ 2–3 ◯ 4–5 ◯ 6–10 ◯ 11–15 ◯ 16–20 ◯ 21–25 ◯ 26 +

TRANSPORTATION
◯ My own vehicle ◯ Ride from friend or relative ◯ Taxi ◯ Walked or Biked ◯ Bus

AGE
◯ Younger than 18 ◯ 18–20 ◯ 21–25 ◯ 26–30 ◯ 31–35 ◯ 36–40 ◯ 41–45 ◯ 46–50 ◯ 51–55 ◯ 56–60 ◯ 61–64

MARITAL STATUS
◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

ESTIMATED HOUSEHOLD INCOME PER YEAR
◯ $0–$10,000 ◯ $10,001–$15,000 ◯ $15,001–$20,000 ◯ $20,001–$25,000 ◯ $25,001–$30,000 ◯ $30,001–$35,000
◯ $35,001–$40,000 ◯ $40,001–$45,000 ◯ $45,001–$50,000 ◯ $50,001–$55,000 ◯ $55,001–$60,000 ◯ more than $60,001

NUMBER IN HOUSEHOLD (including yourself)
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+
OF ADULTS _____ # OF KIDS _____

FINANCIAL SUPPORT
◯ Full-Time Job ◯ Part-Time Job ◯ Not Working ◯ Seeking Work ◯ Not Seeking Work ◯ Government ◯ Relatives

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DOCTOR?
◯ 0 to 2 days ◯ 3 to 5 days ◯ 6 to 7 days ◯ 1 to 2 weeks ◯ 3 to 4 weeks ◯ 2 to 3 months ◯ 4 to 6 months ◯ 7 to 12 months ◯ 1 to 2 years ◯ More than 2 years

WHAT FACTORS LED TO YOUR WAIT FOR CARE? (Check all that apply)
◯ Insufficient funds to pay out of pocket ◯ No insurance ◯ Insurance would not cover treatment ◯ Did not know where to go for help ◯ Did not see my health issues as a problem ◯ Unable to travel to a health care provider ◯ Unable to find the time for an appointment ◯ Other (Please Explain) ↓

_____

HAVE YOU OR WOULD YOU USE THE ER FOR NON-EMERGENCY CARE BECAUSE YOU LACK ACCESS TO CARE?
◯ Yes ◯ No

HOW MANY NON-LIFE-THREATENING ER VISITS HAVE YOU MADE BECAUSE OF YOUR LACK OF ACCESS TO CARE?
◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10+

WHAT BROUGHT YOU TO THE DREAM CENTERS WOMEN'S CLINIC CLINIC? (Check all that apply)
◯ I am new to the area. ◯ I do not have a doctor. ◯ I recently lost health insurance. ◯ I'm employed but have no insurance. ◯ I heard good things about DC Women's Clinic. ◯ Other →

_____

Clinic Policies & Procedures

1. This free clinic provides medical care and treatment for basic women's health concerns.
2. The Dream Centers Women's Clinic is open limited hours and your volunteer or staff provider may have limited office hours. If you have an emergency health condition, call 911. If you have urgent need for care, go to an urgent care facility where you may be seen that day.
3. Three incidences of non-compliance (no show to a clinic or specialty care appointment, failure to take medication, failure to comply with treatment recommendations, failure to attend screening appointments or diagnostic study appointments) will be grounds for immediate termination as a patient of the clinic. **Three no-shows to appointments will result in review of patient status and possible termination.**
4. Persons wishing to see a medical provider must have an appointment.
5. Patients will be considered without regard to race, age, religion, national origin, political or union affiliation, marital status, sex or sexual orientation.
6. Persons who have private insurance, Medicaid, CICP, or other coverage must notify clinic staff for review of eligibility.
7. Medical triage (advice by phone) will generally not be done over the phone. All patients must have an appointment.

Medications Policy

1. Prescriptions will be written, if appropriate, by a provider (nurse practitioner, physician assistant, MD or DO) at the time of appointment. Dream Centers personnel will refer patients to a prescription assistance program when possible.
2. Refill requests must be submitted **seven days prior to needed refill.** Refills will only be granted on a case-by-case basis and may require an office visit. We do not refill any emergency medications.

Referral Policy

1. Dream Centers Women's Clinic has a very limited referral network and all specialists are not available. We cannot accommodate every request for a referral within the existing network. If no specialist is available, the Women's Clinic will provide a list of other specialty providers with which the patient may make other arrangements for care.
2. Testing and diagnostic reports will be provided to the Nurse Manager who will review the results with the ordering provider and make them available to you either by phone, by mail, or at your next clinic appointment.
3. Patients are responsible to notify the Women's Clinic of care received through other clinics or specialty offices.

Reporting Changes

1. All changes to household size, income, address, phone number, and insurance coverage status MUST be reported to the Women's Clinic office within 10 days. Failure to report changes could result in a loss of services.

Services *Not* provided by Dream Centers Women's Clinic

1. Emergency room visits, even when referred by the Women's Clinic.
2. Physician, Nurse Practitioner, Physician Assistant services not authorized by the Women's Clinic or services outside of the scope of practice of the individual volunteer provider.
3. Maternity services.
4. Emergency room follow-up visits. Patients are encouraged to apply for Colorado Indigent Care Program (CICP) and state and local services. Patient should follow-up with physician per emergency room instructions.

I request medical/clinic services from the Dream Centers Women's Clinic. I authorize the Women's Clinic to collect and share information with affiliated providers any health care information.

Patient Signature	Patient Name (Printed)	Date (D/M/Y)	Dream Centers Witness