Prototype Health, Inc.
Adult Registration Form
Confidential Information

Date of Birth_____ ▫ **Male** ▫ **Female**

Last Name _____**First Name**_____ **MI** _____

Other names used_____

Address_____ **Apt #** _____

City_____ **State** _____**Zip Code**_____

Phone:Home(____)_____Work(____)_____Cell(____)_____

Email: _____

Is it ok to call: ▫ Yes ▫No Is it ok to send a letter: ▫ Yes ▫No Is it ok to email: ▫ Yes ▫No

Ethnicity: ▫ Hispanic ▫ Non-Hispanic ▫ Unknown **Preferred Language**:_____

Race: ▫ African or African American ▫ Caucasian or European American ▫ Native Hawaiian or other Pacific Islander ▫ Asian or Asian American ▫ Native American or Native Alaskan ▫ Other/Unknown

Marital Status: ▫Single ▫Married ▫Widowed ▫Divorced ▫Domestic Partner

Financial: This clinic offers a sliding scale based on income. To apply for the sliding scale, please provide the following information:

Family Size: # adults in household:_____# children_____Total Family Income per year:$_____

How did you hear about this clinic?_____

If we did not have this service, where would you go?_____

Insurance: ▫ Yes ▫ No AHCCCS: ▫ Yes ▫ No

In case of emergency, contact:

Name_____Phone(____)_____Relationship_____

STAFF USE ONLY
Payment Source: ▫ Self Pay ▫ AHCCCS ▫ Private Insurance
Sliding Scale: ▫ 0% ▫ 30% ▫ 50% ▫ 75% ▫ 100%

Prototype Health, Inc.

GENERAL CONSENT FOR CARE AND TREATMENT

I, _____(circle one: Patient/Authorized representative), hereby authorize the Prototype Health, Inc. staff and its representatives to render routine health care to myself or to my child _____(write "N/A" or "not applicable" if there is no child).

I authorize the following individuals to obtain medical care for my child in my absence: (write "N/A" or "not applicable" if there is no child).

1. _____ 2. _____ 3. _____

I understand that routine health care is confidential and voluntary and may involve provider office visits that include history taking, examination of all parts of the body, administration of medications, laboratory and diagnostic tests, and/or minor procedures. I further understand that referrals will be made for further diagnosis or treatment if needed and that I am responsible for obtaining such follow-up. I understand that I may discontinue services at any time. I understand that if tests are taken for communicable disease and certain positive results obtained, reporting to the public health department is required by law.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Prototype Health, Inc. I understand that there is a chance for error with laboratory or diagnostic tests performed.

I hereby give my permission to the agency named above to use information contained in my medical record for statistical purposes with the understanding that confidentially will be maintained.

I have been informed of my right and responsibilities regarding eligibility for services.

_____ _____

Signature of Patient/Authorized Representative Date

_____ _____

Witness Date

Prototype Health, Inc.

FINANCIAL POLICY ACKNOWLEDGEMENT

Payment is Due at Time of Service

Forms of payment accepted are:

- Cash
- Debit cards
- Visa
- Mastercard
- Discover
- American Express

Fees May Be Applied for the Following:

- Office Visit
- In-Office Procedures
- In-Office Diagnostic Testing
- Lab Analysis Ordered
- Medicines

In order to evaluate your condition, it may be necessary to conduct tests in the office or administer certain treatments. Please ask to see our fee schedule for more information. You can ask for this at the Reception Desk at any time.

Fees for No-Shows and Missed Appointments

There will be a **$5** fee for all missed appointments. This will be due at the time of the next appointment.

Acknowledgement

I have read and understand the above financial policy and agree to the conditions listed.

_____ _____

Signature of Patient or Authorized Representative Date

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Name_____DOB_____Date_____

Main reason for today's visit_____

Allergies to food or medications:_____Type of reaction:_____
Prescription medicines, over-the-counter medicines, vitamins, supplements:

Name:_____Strength (mg)_____Times per day_____

Name:_____Strength (mg)_____Times per day_____

Name:_____Strength (mg)_____Times per day_____

Name:_____Strength (mg)_____Times per day_____

□ Yes □ No Do you have another health care provider? If yes, who?_____

A. Family Medical History (Mother, Father, Sister, Brother, Aunt, Uncle) (circle all that apply)

Heart attack before age 55	High cholesterol/lipids	Depression/Suicide
Stroke before age 55	Diabetes	Genetic Disorder
Blood clot in legs/lungs	Alcoholism	Thyroid disease
High Blood Pressure	Asthma/COPD	Other illness:_____

Cancer: Ovarian, breast, uterine, testicular Cancer: other_____ □ I do not know my family medical history

B. Personal Medical History
Have you ever been **diagnosed** with the following (circle all that apply):

Anemia	Depression	Heart disease	Ovarian cyst/abnormality
Asthma	Diabetes	Hepatitis	Sickle cell disease
Anxiety	Eating disorder	Infertility	Stroke
Blood clotting disorder	Endometriosis	Kidney disease	Thyroid disease
Blood pressure	Epilepsy or seizures	Lupus	Tuberculosis (TB)
Breast lump	Fibroids	Mental Illness	Undescended testicle
Cholesterol	Gallbladder disease	Migraines	

Cancer type:_____ Other_____

C. Symptom History
Circle any symptoms you CURRENTLY have, or have RECENTLY had:

Fever	Nausea/vomiting	Breast lump
Chest pain	Abdominal pain	Nipple discharge
Palpitations	Constipation	Pain/bleeding with sex
Cough	Diarrhea	Blood clot in legs/lungs
Difficulty breathing	Blood in stool	Problems with urination
Change in appetite/thirst	Trouble swallowing	Unusual vaginal discharge
Unexplained weight change	Rash	Vaginal bleeding
Unexplained fatigue	Joint pain	Penis discharge
Easy bruising/bleeding	Muscle/back pain	Pain in scrotum
Fainting	SEVERE headaches	Concern with sexual function
Anxiety	Ear problems	Change in moles
Depression	Nose problems	
Sleep problems	Mouth problems	Other_____
Memory loss	Changes in vision NOT related to needing glasses	

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C. Hospitalization/Surgical History

□Yes □No Type_____Year_____
Type_____Year_____
Type_____Year_____
□Yes □No Blood Transfusion Date_____

D. Vaccination History

When was the last time you had a vaccination?_____

E. Social History

□Yes □No Currently smoke cigarettes? How many per day_____□Yes □No Interested in quitting?
□Yes □No Past smoker? If yes, when did you quit?_____
□Yes □No Other tobacco? What kind ?_____How many per day?____□Yes □No Interested in quitting?
□Yes □No Do you drink alcohol? If yes, how many drinks per day_____□Yes □No Interested in quitting?
□Yes □No Recreational/street drugs? What kind ?_____How often?_____□Yes □No Interested in quitting?
□Yes □No Caffeine use How many per day_____
□Yes □No Do you feel threatened by your partner?
□Yes □No Do you feel physically safe in your current relationship?
□Yes □No If you ask them, does your partner refuse to use a condom?
Have you ever had a sex partner with a history of:
□Yes □No Injected drug use □Yes □No Sex with men □Yes □No HIV

F. Sexual Health History

□Yes □No Currently sexually active □Yes □No Sexually active in the past
□ I have never had vaginal intercourse
How many total sexual partners have you had?____
How long have you been with your current sexual partner?_____
How many partners have you had in the past 12 months?_____
Do you have sex with: □ Men □ Women □ Both
Do you participate in: □ Oral sex □ Vaginal sex □ Anal sex □ Outer-course
□Yes □No Had an HIV test? When?_____ □ Positive □ Negative
Have you had any of the following:
□ Chlamydia □ Gonorrhea □ Herpes □ Syphilis □ PID □ Genital warts □ HPV

G. Birth Control History

□Yes □No Currently using birth control. If yes, what type are you or your partner using?_____
What types of birth control have you used in the past?

□ Abstinence	□ vaginal ring	□ DepoProvera/shot	□ Diaphragm/cervical cap
□ Pills	□ patch	□ IUD type_____	□ Rhythm/Natural Family Planning
□Condoms/rubbers	□ Foam/film/jelly	□ Implant under the skin	□ Withdrawal/pulling out
□ Sterilization/tubes tied/vasectomy		□ None	

H. FOR MEN

□Yes □No Have you ever gotten someone pregnant? □ Don't know
□Yes □No Do you and your partner want to get pregnant in the next year?
□Yes □No Have you had a PSA (prostate) test? □ Don't know

Patient Signature_____Date_____

Provider Signature_____Date_____

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I. FOR WOMEN

Menstrual History
When was the first day of you last period?_____ □Yes □No Was it normal?
Age periods started?_____Periods come every_____days and they last _____days
Periods are □ regular □ irregular □ light □ moderate □ heavy □ painful
□Yes □No Bleeding/spotting between periods

Pregnancy History
How many times have you been pregnant?_____
Number of live births_Number of living children_____Ages of children_____
Birth Defects?_____Number of premature_____Number of c-sections_____
Number of ectopic_____Number of abortions_____Number of miscarriages_____
□Yes □No Mother used DES when she was pregnant with you □ Don't know
□Yes □ No Are you breastfeeding?
□Yes □ No Do you have plans for pregnancy in the next year?

Screening History
When was your last Pap Smear? _____
□Yes □No Abnormal Pap smear in past? When?_____

Have you had any of the following?
□Colposcopy □ Cryosurgery □ LEEP

□Yes □No Have you had a mammogram? When? _____
□Yes □No Was it normal?

I give the above information freely. It is complete and correct to the best of my knowledge.

Patient Signature_____Date_____

Provider Signature_____Date_____