Southern Trinity Health Services, Inc.

Mad River – 321 Van Duzen Road/P.O. Box 4, Mad River, CA 95552, 707-574-6616
Scotia Bluffs – 500 B Street/P.O. Box 7, Scotia, CA 95565, 707-764-5617
Providing Compassionate, High Quality & Preventative Health Care Regardless of Ability to Pay

Name: (First, Middle, Last)		**Gender Identity Required: (circle one)** Transgender male/female to male Transgender female/male to female	Male / Female Other Chose not to disclose	
Sexual Orientation Required: (circle one) Straight or heterosexual Bisexual Lesbian, gay or homosexual Something else Chose not to disclose Don't know	**Date of Birth:**	**Social Security Number Required:**	**Smoker:** Yes / No	**Veteran:** Yes / No
Mailing Address: (Street/P.O. Box- City-State- Zip)				
Email Address Required:		**Pharmacy:** (Name and Location)		
Home Phone Number:	**Cell Phone Number:**		**Work Phone Number:**	
Marital Status: Single / Married / Separated / Divorced / Widowed Name of Spouse (if applicable):_____		**Work Status:** Student / Homemaker / Unemployed / Retired Employed: Full Time / Part Time / Self		
Employer/Company Name:		Occupation:		
Employer Address: (Street-City-State-Zip)			Employer Phone Number:	
Emergency Contact (Name/Relationship) Required:			**Emergency Contact Phone Number:**	
(If Patient Is A Minor) Responsible Party: (Name/Relationship)		Responsible Party Address: (Street/P.O. Box-City-State-Zip)		
Responsible Party Phone Number:	Responsible Party Social Security Number:		Responsible Party Date of Birth:	

May we discuss your medical record information over the phone or in person with your designated personal representative (example: spouse, family member or friend)? Yes / No
If yes, whom?_____

I hereby acknowledge or opt out of receiving a copy of STHS Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose. Refusal __Emergency situation __Communication Barrier__
If you would like a copy of the Notice of Privacy Practices it will be given to you at your request. Initial here____

Signature of Patient / Parent or Guardian_____Date_____

Do you have medical insurance coverage? Insurance card required	Yes / No
Primary Insurance Name:	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth
Subscriber's Employer	
Secondary Insurance Name (if applicable): Insurance card required	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth:
Subscriber's Employer	
Do you have dental insurance coverage? Insurance card required	Yes / No
Dental Insurance Name (if applicable):	
Policy/ID Number:	Group Number:
Subscriber Name:	Subscriber's Relationship to Patient:
Subscriber's Social Security Number:	Subscriber's Date of Birth:
Subscriber's Employer	

Insurance: You are responsible for your insurance coverage and ensuring that the services you receive here are covered under your plan and verifying preferred provider status. You are responsible for notifying us of any changes in your insurance. We will bill your insurance for you, and make a reasonable effort to collect from them, however you remain responsible for what your insurance does not pay.

Co-Payments: You are responsible for your co-payment which is due at time of service, you will be asked to pay it when you check in for your visits.

Private Pay & High Deductible: If you are private pay or have a high deductible, or your insurance will pay you directly, you will be asked to pay for your visit at the time of service. We offer a sliding fee schedule for patients based on federal guidelines.

Sliding Fee Discount Program: It is the policy of STHS to provide services regardless of the patient's ability to pay. Discounts are offered depending upon household income and size per federal guidelines beginning each year on April 1st thru March 31st. The discount will apply to all services received in our office only, but not the services which are purchased from outside.

Please inquire at the front desk if interested in this program to see if you qualify.

Treatment Agreement: for Southern Trinity Health Services: The above information is true to the best of my knowledge. I request STHS to provide me and/or my family with medical and/or dental care.

Payment Agreement: I authorize assignment of benefits for services received to be paid directly to STHS. I understand that I am financially responsible for any balance. I also authorize STHS or my insurance company to release any information required to process my claims.

This includes all minor patients as acknowledged by parent or legal guardian.

Signature of Patient / Parent or Guardian_____Date_____

Demographic Information
The following information is requested by the Federal Government in order to monitor compliance with Federal law prohibiting discrimination against users of Southern Trinity Health Services and Scotia Bluffs Community Health Center. You are not required to furnish this information, but are encouraged to do so. This information will not be used to discriminate against you in any way, nor will it be released except in aggregate form.

Please check one box in each of the following categories:

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race:
☐ Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Alaska Native
☐ White (not Hispanic or Latino)
☐ More than one Race
☐ Not Reported/Refuse to Report
Primary Language:
☐ English
☐ Spanish
☐ Other:
Migrant/Seasonal Worker:
☐ Migrant Worker
☐ Seasonal Worker
☐ Not a Migrant/Seasonal Worker
Housing Status:
☐ Doubling Up
☐ Not Homeless
☐ Shelter
☐ Street
☐ Transitional
☐ Unknown/Unreported

Income Category		
	# In Family	Annual Family Income
☐	1	$0-$12,140
☐	1	$12,141-$18,210
☐	1	$18,211-$24,280
☐	1	More Than $24,281
☐	2	$0-$16,460
☐	2	$16,461-$24,690
☐	2	$24,691-$32,920
☐	2	More Than $32,921
☐	3	$0-$20,780
☐	3	$20,781-$31,170
☐	3	$31,170-$41,560
☐	3	More Than $41,561
☐	4	$0-$25,100
☐	4	$25,101-$37,650
☐	4	$37,651-$50,200
☐	4	More Than $50,201
☐	5	$0-$29,420
☐	5	$29,421-$44,130
☐	5	$44,131-$58,840
☐	5	More Than $58,841
☐	6	$0-$33,740
☐	6	$33,741-$50,610
☐	6	$50,611-$67,480
☐	6	More Than $67,481
☐	7	$0-$38,060
☐	7	$38,061-$57,090
☐	7	$57,091-$76,120
☐	7	More Than $76,121
☐	8	$0-$42,380
☐	8	$42,381-$63,570
☐	8	$63,571-$84,760
☐	8	More Than $84,761

Signature of Patient / Parent or Guardian_____**Date**_____

Date: _____ **Clinical History** DOB: _____

Name: _____ ___ _____ Age: ___ Sex: _____ Race: _____ Ph#: _____
First M.I. Last

Address: _____ _____ _____ _____ Insurance: _____
Street City State Zip

Allergies or Adverse Reactions ---------- □ None

Substance	Reaction	Substance	Reaction

Past Medical History ---------- □ None

Please indicate with √ for current or chronic conditions and provide date of onset, and X for past conditions and give date.

Glaucoma	□		Kidney Disease	□		Eczema	□	
Macular Degeneration	□		Diabetes	□		Psoriasis	□	
Asthma	□		Thyroid Disease	□		Hepatitis (type:)	□	
Emphysema	□		Anemia	□		Tuberculosis	□	
Hypertension	□		Seizure Disorder	□		STDs	□	
Heart Disease	□		Stroke	□		Anxiety	□	
GERD	□		Arthritis	□		Depression	□	
Ulcers	□		Gout	□		Mental Illness	□	
Diverticulosis	□		Osteopenia/porosis	□		Other _____	□	
Kidney Stones	□		Spinal Disease	□		Other _____	□	

Past Surgical History and Major Hospitalizations ---------- □ None

Have you ever had a blood transfusion? □ No □ Yes—date: _____

Date	Operation	Date	Operation/Hospitalization	Date	Hospitalization

Current Medications ---------- □ None

Medication	Dose	Frequency	Medication	Dose	Frequency

Immunizations

Please check the box if you have had the following shots:

□ Hepatitis A □ Hepatitis B
□ Flu □ Pneumonia
□ Tetanus—date: _____

Social History

Marital Status: M W D Sep Single
Highest Grade in School: _____
Occupation: _____
Support Sys/Religion: _____
Hobbies: _____

Habits

□ Caffeine—Type _____ Amt/day: _____
Tobacco: □ Never □ Present □ Past
Type: _____ Amt/day: _____ for ____ yrs
□ Alcohol—Type _____ Amount: _____
□ Drug Use—Type _____

Family History ---------- □ None

Please check the box if any blood relatives have suffered from any of the following conditions, state their relationship to you, and give their age at onset.

Heart Attack □ _____	Depression □ _____	Blood Disorder □ _____
Other Heart Disease □ _____	Other Mental Illness □ _____	Birth Defects □ _____
High Blood Pressure □ _____	Migraine Headaches □ _____	Retardation □ _____
Stroke □ _____	Glaucoma □ _____	Inherited Disease □ _____
Cancer □ _____	Allergies □ _____	Other _____ □ _____
Diabetes □ _____	Asthma □ _____	Other _____ □ _____
Thyroid Disease □ _____	Tuberculosis □ _____	Other _____ □ _____
Arthritis □ _____	Bowel Problems □ _____	Other _____ □ _____
Gout □ _____	Ulcers □ _____	Other _____ □ _____

Southern Trinity Health Services Reviewed by: _____ Date: _____

Date: _____ Name: _____ ___ _____ DOB: _____
First M.I. Last

Review of Systems

Please check the box if you currently have or have recently had any of the following conditions:

Constitutional □ None

□ Change in Appetite
□ Fatigue
□ Fever
□ Sweats
□ Unintentional Weight Loss
□ Other _____

Eyes □ None

□ Blindness
□ Blind Spots
□ Blurred Vision
□ Double Vision
□ Frequent Eye Infections
□ Excess Tearing
□ Previous Eye Injury
□ Cataracts
□ Failing Vision
□ Glasses
□ Contacts
□ Other _____

Ears, Nose, Throat, & Mouth □ None

□ Decreased Hearing
□ Ringing in Ears—□ Right □ Left □ Both
□ Frequent Ear Infections
□ Abnormal Ear Discharge
□ Ear Pain
□ Excessive Noise Exposure
□ Hearing Aid
□ Dizzy Spells
□ Excessive Sneezing
□ Frequent Runny Nose or Congestion
□ Sinus Trouble
□ Recurrent Nose Bleeds
□ Tooth Pain
□ Dentures
□ Frequent Sore Throats
□ Prolonged Hoarseness
□ Other _____

Cardiovascular □ None

□ Chest Pain
□ Palpitations
□ Irregular Pulse
□ Heart Murmur
□ Swollen Ankles
□ Leg Muscle Pain When Walking
□ Phlebitis
□ Varicose Veins
□ Other _____

Respiratory □ None

□ Chronic Cough
□ Shortness of Breath
When? _____
□ Wheezing
□ Coughing Up Blood
□ Sputum Production
□ Other _____

Gastrointestinal □ None

□ Bloody Stools
□ Tarry Stools
□ Hemorrhoids
□ Chronic Abdominal Pain
□ Recent Change in Bowel Habits
□ Diarrhea
□ Constipation
□ Jaundice
□ Persistent Nausea/Vomiting
□ Indigestion
□ Heartburn
□ Difficulty Swallowing
□ Other _____

Musculoskeletal □ None

□ Deformity—Where? _____
□ Pain—Where? _____
□ Swelling—Where? _____
□ Weakness—Where? _____
□ Previous Injury—Where? _____
□ Other _____

Neurological □ None

□ Confusion
□ Memory Loss
□ Fainting Spells
□ Frequent Headaches
□ Muscle Weakness
□ Numbness/Tingling
□ Other _____

Psychiatric □ None

□ Excessive Moodiness
□ Difficulty Concentrating
□ Difficulty or Excessive Sleeping
□ Abnormal Thoughts
□ Nervousness
□ Phobias
□ Recent Stressful Life Event _____
□ Other _____

Skin □ None

□ Abnormal Moles
□ Hives/Rashes
□ Itching
□ Other _____

Genitourinary—Female □ None

Age of menstrual onset _____
Date of last menses _____
Birth control method _____
No. of pregnancies _____
No. of live births _____
No. of miscarriages _____

□ Painful Menses
□ Excessive or Prolonged Bleeding
□ Pain or Bleeding After Sex
□ Sexual Dysfunction
□ Flushing/Menopause
□ Infertility Problems
□ Abnormal Pap Smear
□ Vaginal or Urethral Discharge
□ Frequent Urine Infections
□ Painful Urination
□ Strong Smell to Urine
□ Blood in Urine
□ Change in Urine Color
□ Loss of Bladder Control
□ Overnight Urination More Than Twice
□ Pelvic Pain
□ Hernia
Other _____

Genitourinary—Male □ None

□ Abnormality of Testicles
□ Sexual Dysfunction
□ Urethral Discharge
□ Frequent Urine Infections
□ Painful Urination
□ Strong Smell to Urine
□ Blood in Urine
□ Change in Urine Color
□ Overnight Urination More Than Twice
□ Hernia
□ Other _____

Endocrine □ None

□ Enlargement of Thyroid Gland
□ Excessive Thirst
□ Hair Loss or Abnormal Growth
□ Heat or Cold Intolerance
□ Hot Flashes
□ Other _____

Hematological/Lymphatic □ None

□ Easy Bruising/Bleeding
□ Swollen Glands
□ Other _____

Procedures and Studies □ None

Please check the box and give the most recent approximate date if you have had any of the following:

Dental Exam □ _____
Hearing Test □ _____
Eye Exam □ _____
Pap Smear □ _____
Rectal Exam □ _____

Colonoscopy □ _____
Chest X-ray □ _____
EKG □ _____
Exercise Stress Test □ _____
TB Test □ _____

Blood Sugar □ _____
Cholesterol □ _____
PSA □ _____
Other Blood Work □ _____
Other □ _____

Southern Trinity Health Services Reviewed by: _____ Date: _____

Decline or Start Sharing/Information Request

PLEASE CHECK (√) THE STATEMENT(S) BELOW THAT APPLY:	
MY FULL NAME:	**RELATIONSHIP TO PATIENT** ☐ self ☐ parent/guardian
Name of Patient:	Patient's Street Address:
Patient Date of Birth:	Patient's City/Zip Code:
Patient ID (optional):	Patient County:
Patient Phone:	

DECLINE SHARING

☐ **I DECLINE to allow my/my child's immunization/ tuberculosis (TB) screening test record to be shared with other health care providers, agencies, or schools in the California Immunization Registry (CAIR).***

** Note: The immunization record/TB Tests may still be recorded in the registry for use by your physician's office. By law, public health officials can also access immunization/TB test records in the case of a public health emergency.*

START SHARING (Declined earlier, now have changed mind and wish to share.)

☐ **I ALLOW my/my child's immunization/TB test record to be shared with other health care providers, agencies, or schools in CAIR.**

REQUEST INFORMATION

☐ I REQUEST a list of agencies who have viewed my/my child's CAIR immunization/TB test record.

☐ I REQUEST to review or correct my/my child's CAIR immunization/TB test record. I understand that any changes made to this record must be verified by appropriate documentation from my health care provider.

Signature:	**Date:**

Fax or email this form to the CAIR Help Desk at
1-888-436-8320, CAIRHelpDesk@cdph.ca.gov

Southern Trinity Health Services
Southern Trinity Area Rescue

Serving Southern Trinity & Southeastern Humboldt Since 1979

Dear Patient,

This letter is to inform you of your responsibilities regarding missed appointments.

According to our Missed Appointment Policy, the following steps are taken to ensure that all patients are aware and understand their responsibilities and rights regarding the occasional but sometimes necessary need to reschedule an appointment. An appointment where the patient does not appear or cancels with less than 24 hours' notice are both considered missed appointments for the purpose of our policy.

1) Southern Trinity Health Services makes reminder calls 48 and 24 hours before your appointment to allow you the opportunity to cancel an appointment.

2) All missed appointments will be recorded in your chart.

3) Missed appointments receive a follow-up call and letter notifying the patient of the recorded missed appointment.

Dental Policy

4) Dental patients will only be allowed two (2) missed appointments. At this time they will not be given the option to schedule appointments and will be required to call on a daily basis to see if an opening is available.

Medical / Behavioral Health Policy

5) Medical and behavioral health patients that miss more than three (3) visits within two (2) years will be reviewed and will only be considered for same-day appointments.

Patient Signature: _____

Date: _____

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www.sthsclinic.org