999 W. Amador Ave., Las Cruces, NM 88005 (575) 527-5482 Voice 575-652-4243 Fax

Patient Information

Last Name________________________ **First Name**______________________ **Middle**_______________________

Preferred First Name:______________________________________

Social Security #____ **Date of Birth** __________________________

Address____ **City**_____________________________

State_________________________ **Zip Code**____________________ **Phone** (   ) ________________________

Work Phone (   )____________________ **Email address:** ____

Emergency Contact (   )___________________ **Relationship:** ____

Race: *(Select One)*
- ☐ White
- ☐ African American
- ☐ Native American
- ☐ Other:__________
- ☐ Decline to Answer

Homeless status: *(Select One)*
- ☐ Doubling up
- ☐ Not Homeless
- ☐ Shelter
- ☐ Street
- ☐ Transitional

Migrant Worker: *(Select One)*
- ☐ Migrant
- ☐ Not a Farm Worker
- ☐ Seasonal

Ethnicity: *(Select One)*
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Decline to Answer

How did you hear about us?
- ☐ Word of Mouth
- ☐ Television
- ☐ Radio
- ☐ Hospital
- ☐ Patient of the Clinic
- ☐ Insurance Company
- ☐ Outreach Event
- ☐ Search Engine (Google, Yahoo, Etc.)
- ☐ Social Media
- ☐ Other

Preferred Spoken/ Written Language: *(Select One)*
- ☐ English
- ☐ Spanish
- ☐ Other:____________

Primary Medical Coverage:______________________________ **Policy Number:**____________________________________

Primary Pharmacy:___________________________________ **Address:**____

Birth Sex: *(Select one)* *For billing purposes*
- ☐ Female
- ☐ Male

Gender Identity: *(Select one)*
- ☐ Male/Man
- ☐ Female/Woman
- ☐ Transgender Male/Trans Man (FTM)
- ☐ Transgender Female/Trans Female (MTF)
- ☐ Genderqueer, Gender Nonconforming
- ☐ Something else, please describe ________________________
- ☐ Decline to Answer

Preferred Pronouns: *(Select one)*
- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other: ____________________

Sexual Orientation: *(Select one)*
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay, or Homosexual Bisexual
- ☐ Queer, pansexual, and/or questioning
- ☐ Something else, please describe ____________________
- ☐ Don't know
- ☐ Decline to answer

Veteran: *(Select One)*
- ☐ Yes
- ☐ No

Patient (Or Guardian) Consent for Treatment:

I authorize the providers of Amador Health Center to examine, diagnose, and recommend treatment for me or the person under my care.

ASSIGNMENT OF BENEFITS TO PROVIDER:

I only certify that the information provided on this form is correct to the best of my knowledge.

X ______________________________

Patient Signature

____

Print Name of Patient

____

Date Relationship

Consent for communication methods: (Circle One)

Text: Yes No

Call: Yes No

Email: Yes No

AMADOR HEALTH CENTER NO SHOW POLICY

Amador Health Center works diligently to see all patients that come in to see a provider. Because of that reason we will only allow 3 no-shows. After that, appointments will not be made for you. You will only be seen as a walk-in and may experience long waiting times. Please call us if you are unable to make your appointment at (575)-527-5482.

I have read this policy and understand.

Signature____________________________________Date ___________________________

Print Name ___________________________________

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

____ ________________________

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Amador Health Center may use or disclose my protected health information for treatment, payment, or health care operations- which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures for this information without my authorization.

Amador Health Center has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Amador Health Center will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Amador Health Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Amador health center has taken action relying on this consent.

____ ______________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ ______________

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting:

Amador Health Center
999 W. Amador, Suite A
Las Cruces, NM 88005
Phone: 575-527-5482
Fax: 575-652-4243

Medical History

Name:____**Date of Birth:**_________/_______/_________

Please indicate if **YOU** have a history of the following:

□ Anemia
□ Anxiety Disorder
□ Arthritis
□ Asthma
□ Autoimmune Problems
□ Bladder Problems
□ Bleeding Disease
□ Blood Clots
□ Blood Transfusion(s)
□ Bowel Disease
□ Depression
□ Diabetes
□ Heart Attack
□ Heart Disease
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Liver Disease
□ Lung/ Respiratory Disease
□ Mental Illness
□ Migraines
□ Osteoporosis
□ Reflux/ GERD
□ Seizures/ Convulsions
□ Sexually Transmitted Disease
□ Skin Cancer
□ Stroke/ CVA of the Brain
□ Suicide Attempt
□ Thyroid Disease
□ Ulcer
□ Other Disease, Cancer, or Significant Medical Illness/
□ **NONE of the above**

List other medical problems: ____

Medication Allergies
Name_______________________________________Reaction You Had ____
□ I have no known **Medication** allergies

Family Medical History

Please indicate if **YOUR FAMILY** has a history of the following:
(**ONLY** include parents, grandparents, siblings, and children)

□ I am adopted and do not know biological family history
□ Family History Unknown
□ Alcohol Abuse
□ Anemia
□ Arthritis
□ Asthma
□ Bladder Problems
□ Bleeding Disease
□ Breast Cancer
□ Colon Cancer
□ Depression
□ Diabetes
□ Heart Disease
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Lung / Respiratory Disease
□ Other Cancer
□ Rectal Cancer
□ Seizures/ Convulsions
□ Stroke/ CVA of the Brain
□ Thyroid Problems
□ Mother, Grandmother, or Sister developed heart disease before the age of 65
□ Father, Grandfather, or Brother developed heart disease before the age of 55
□ **NONE of the Above**

Preventative History

Colonoscopy**:** □Y □N
Date: _____________
Have you had a Tetanus shot?
□Y □N If yes, how long ago?_____
For Women
Papsmear: □Y □N Date: _________
For Men
Prostate Cancer Screening**:**
□Y □ N Date:_______________

Social History

Do you drink alcohol? □Y □N
IF Yes, drinks/week: _____________
Do you currently:
Smoke / Chew / Vape tobacco?
□Y □N
If No, previously □Y □N
Years smoked Packs/day_______
Do you drink Caffeine? □Y □N
Do you use illegal drugs? □Y □N

Social History Questionnaire

Occupation: ____

Employment:_________Full-time________Part-time________Retired________Unemployed________Not working due to WC injury

Marital Status:_______Single________Married________Divorced________Widowed

Number of Children:________________

Do you exercise? Yes / No **What type of exercise:**________________**How often:** ______________________

Declaration Of Income Statement

I,____do hereby declare on (date)________________that:
(Applicant's name) (Date)
*My household consists of____persons and the following household members:____________________________________

____

*My household's gross income, for all household members 18 years and older, for the 30 day period prior to the date of the application assistance is $__________________________

_______I DECLINE TO GIVE ANY INFORMATION AT THIS TIME

I understand I need proof of income in order to be on the sliding scale, I have documented proof and will be providing the following:______Federal Income Tax return_____One month's worth of check stubs
____Letter From Employer ____Letter From Federal Disability

I have no document proof of income at this time due to the following: ____Homelessness ____Have zero income
____Get paid cash

I certify that the adobe information for the income is true and correct to the best of my ability.

_X____ _______________
Signature Date

____ ____________
Reviewed by Date

Amador Health Center SDOH Assessment Questionnaire (Based on PRAPARE)

1. **Are you worried about losing your housing?**
   a. ☐Yes
   b. ☐No
   c. ☐I choose not to answer this question.
2. **What is the highest level of school that you have finished?**
   a. ☐Less than high school degree
   b. ☐High school diploma or GED
   c. ☐More than high school
   d. ☐I choose not to answer this question.
3. **During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.**
   a. ____________________
   b. ☐I choose not to answer this question.
4. **In the past year, have you or any family members you lived with unable to get any of the following when it was really needed? Check all that apply.**
   a. Food: Yes ☐ No☐
   b. Utilities: Yes☐ No☐
   c. Medicine or Health Care: Yes☐ No☐
   d. Phone: Yes☐ No☐
   e. Clothing: Yes☐ No☐
   f. Child or Elder Care: Yes☐ No☐
   g. Other (please write): Yes☐ No☐
   h. ☐I choose not to answer this question.
5. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**
   a. ☐Yes, it has kept me from medical appointments.
   b. ☐Yes, it has kept me from non-medical meetings, appointments, work or from getting things that I need.
   c. ☐No
   d. ☐I choose not to answer the question.
6. **Are you a refugee?**
   a. ☐Yes
   b. ☐No
   c. ☐I choose not to answer this question.
7. **How often do you see or talk to people that you care about or feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**
   a. ☐Less than once a week
   b. ☐1 or 2 times a week
   c. ☐3 to 5 times a week
   d. ☐5 or more times a week
   e. ☐I choose not to answer this question.
8. **Stress is when someone feels tense, nervous, anxious or can't sleep at night because their mind is troubled. How stressed are you?**
   a. ☐Not at all
   b. ☐A little bit
   c. ☐Somewhat
   d. ☐Quite a bit
   e. ☐Very much
   f. ☐I choose not to answer this question.
9. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center or juvenile correctional facility.**
   a. ☐Yes
   b. ☐No
   c. ☐I choose not to answer this question.
10. **Do you feel physically and emotionally safe where you currently live?**
    a. ☐Yes
    b. ☐No
    c. ☐I choose not to answer this question.
11. **In the past year, have you been afraid of your partner or ex-partner?**
    a. ☐Yes
    b. ☐No
    c. ☐Unsure
    d. ☐I have not had a partner in the past year.
    e. ☐I choose not to answer this question.