Sunshine FAMILY CARE

Patient Registration/Behavioral Risk Assessment

Date Form Completed: ____/_____/_____

The information disclosed below allows SFC to determine the needs/resources for you and the health needs of our community. The information in your medical record is confidential and protected. Your written consent will be required to release information except in the case of a court order.

Legal Name **Last** **First** **Middle Initial**

Preferred Name:

Legal Sex (please check one) * ☐ Female ☐ Male

**While Sunshine recognizes several genders/sexes, many insurance companies and legal entities, unfortunately, do not. Please be aware that the name and sex listed on your insurance must be used on insurance, billing, and correspondence documents. Please let us know if your preferred name and pronouns differ from these.*

Pronouns:
☐ He, Him, His ☐ She, Her, Hers
☐ They, Them, Their ☐ Other _____

Date of Birth (MM/DD/YYYY)
_____/_____/_____

Language most comfortable speaking: ☐ English ☐ Other _____
Do you need an interpreter? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No
Do you need a sign language interpreter? ☐ Yes ☐ No

Demographic Information

Address **City** **State** **County** **Zip**

Social Security #

Cell Phone **Ok to leave a voicemail?**
(____) _____-_____ ☐ Yes ☐ No

Alternative Phone **OK to leave a voicemail?**
(____) _____-_____ ☐ Yes ☐ No

Email Address:

Ok to email?
☐ Yes ☐ No

Health Insurance: ☐ None ☐ Private/Employer ☐ Medicaid ☐ Medicare
Insurance Carrier Name:_____ Insurance ID # _____
Secondary Insurance Name: _____ ID # _____

Emergency Contact Name **Relationship to you** **Phone Number**

Marital Status:
☐ Divorced/Separated
☐ Single ☐ Married
☐ Widowed
☐ Life Partner
☐ Other _____

Race: **Select all that apply**
☐ American Indian or Alaska Native
☐ Asian or Asian American
☐ Black or African American
☐ Middle Eastern or Northern African
☐ Native Hawaiian or another Pacific Islander
☐ White ☐ Other _____

Veteran Status:
☐ Non-Veteran
☐ Veteran

Ethnicity:
☐ Non-Hispanic
☐ Hispanic, Latino, Latina, or Latinx

Employment Status **Occupation:** **Employer/School:**
☐ Employed full-time ☐ Employed part-time
☐ Self-employed ☐ Student full-time
☐ Student part-time ☐ Retired
☐ Unemployed ☐ Other_____

Identified Gender: **Select all that apply** ☐ Man ☐ Woman
☐ Non-binary/ Genderqueer/not exclusively male or female
Are you Transgender or transsexual? ☐ Yes ☐ No
☐ M to F ☐ F to M ☐ Another Gender

Sexual Orientation:
☐ Lesbian, gay, or homosexual
☐ Straight or heterosexual
☐ Bisexual ☐ Something else ☐ Do not know

Referral Source:
☐ Self ☐ Friend/Family ☐ Health Provider ☐ Emergency Room ☐ Ad/Internet/Media ☐ Work/School ☐ Other _____

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Reason for Visit or Testing: Select all that apply

☐ Establish Primary Care ☐ Establish HIV Care ☐ Regularly HIV/STI test ☐ Medical Provider Referral

☐ Symptoms of STI ☐ Symptoms of HIV ☐ Prenatal Testing ☐ Partner Testing

☐ Recent HIV Exposure (Between 15-30 days) ☐ Exposed to STI (chlamydia, Gonorrhea, Syphilis, Hepatitis)

☐ Court Ordered ☐ HIV Pre Exposure Prophylactic (PrEP) ☐ HIV Non-occupational exposure (nPEP)

☐ Other (Please specify) _____

Medical History

An accurate medical, social, and family history is very important for Sunshine Family Cares, Inc. to best assess your current medical health and influences on future health and well-being.

Please mark any of the following that you are currently having. ☐ Tiredness ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss	**Eyes** ☐ Blurred Vision ☐ Eye Drainage ☐ Eye Pain ☐ Light Sensitivity ☐ Double Vision	**Ear, Nose, and Throat** ☐ Hearing Problems ☐ Ear Ringing ☐ Nosebleeds ☐ Hoarseness ☐ Sore Throat	**Heart, Cardiovascular** ☐ Chest Pain / Pressure ☐ Dizziness ☐ Palpitations ☐ Feet Swelling ☐ Varicose Veins
Respiratory ☐ Cough ☐ Shortness of Breath ☐ Blood-colored Sputum ☐ Wheezing	**Gastrointestinal** ☐ Abdominal Pain ☐ Diarrhea ☐ Blood in Stool ☐ Nausea ☐ Vomiting	**Genitourinary** ☐ Painful to urinate ☐ Blood in urine ☐ Frequent Urination ☐ Unable to hold urine ☐ Pain in your back in the kidney area	**Musculoskeletal** ☐ Joint Pain ☐ Back Pain ☐ Joint Stiffness ☐ Pain in Arms or Legs ☐ Muscle Pain
Skin/Breast ☐ Sores ☐ Moles ☐ Itching ☐ Rash ☐ Breast Pain/Tenderness ☐ Breast Lump	**Neurological** ☐ Fainting ☐ Headaches ☐ Confusion ☐ Memory Loss ☐ Numbness ☐ Tingling ☐ Seizures	**Hematological/Endocrine** ☐ Easy Bruising ☐ Excessive Bleeding ☐ Lymph Node Swelling ☐ Anemia	**Psychologic** ☐ Depression ☐ Anxiety ☐ Severe Stress ☐ Sleep Disturbances ☐ Bi-Polar/Schizophrenia

Allergies ☐ No Known Allergies ☐ Latex ☐ Food: _____

☐ Medications: Please List Medication Allergies:

Preferred Pharmacy	**Address**	**Phone**

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Past Medical History and Behavioral Information

Please select if you have had any of the following:

☐ Arthritis ☐ Asthma ☐ Bleeding Difficulties ☐ COPD ☐ Depression ☐ Diabetes ☐ Insomnia/Difficulty Sleeping ☐ Kaposi's Sarcoma	☐ Emphysema ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Pneumonia ☐ Cytomegalovirus	☐ HIV ☐ Kidney Disease or Stones ☐ Migraines ☐ Osteoporosis ☐ Seizure Disorder ☐ TB/Tuberculosis ☐ Toxoplasmosis ☐ Thyroid Disorder/Disease	☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HPV (warts, Human papillomavirus) ☐ Herpes ☐ Cancer (type and treatment) _____

My sex partner(s) is (are): ☐ Men ☐ Women ☐ Non-binary ☐ Other _____ **Do you use condoms?** ☐ Always ☐ Sometimes ☐ Never	**How many sex partners have you had in the past year? (this includes oral, anal, and vaginal sex)** _____ **In the past 5 years, have you had sex with the following? Select all that apply:** ☐ Male ☐ Female ☐ Transgender ☐ Someone who has injected drugs	**Do you have (check all that apply)** ☐ Oral sex (mouth to genitals) ☐ Vaginal sex (penis to the vagina) ☐ Anal Sex (penis to butt) ☐ Sex toys ☐ Other _____

Prescriptions, including over the counter medications, vitamins, and supplements.

Name of Med/Vitamins	Reason Taking	Dosage	How many Per Day

Past Surgical History (Tonsils, appendectomy, gallbladder)

Surgery	Date

Have you had sex while under alcohol and/or drug use? ☐ Yes ☐ No	Have you ever traded sex for money and/or drugs? ☐ Yes ☐ No	Do you inject drugs? ☐ Yes ☐ No If Yes, Do you share your equipment and/or needles? ☐ Yes ☐ No	
Do you have sex with men who have sex with other men? ☐ Yes ☐ No ☐ Unknown	Have you ever been tested for HIV? ☐ Yes ☐ No If Yes, Date of the last test: _____	Have you ever had sex with someone with HIV? ☐ Yes ☐ No ☐ Unknown	Have you had sex with someone who exchanges sex for money and/or drugs or someone who injects drugs? ☐ Yes ☐ No ☐ Unknown
Do you currently feel safe at your place of residence? ☐ Yes ☐ No	Have you ever been a victim of abuse: ☐ Yes ☐ No (select all that apply): ☐ Mental/Verbal ☐ Physical ☐ Rape/assault	If you have been a victim of abuse, has it: ☐ It has been reported and resolved ☐ It has not been reported, but it has been resolved ☐ Not been reported or resolved	

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Social History			
Spiritual and/or Religious Preferences: ☐ No ☐ Yes, Please list:	**Education** ☐ Highest Grade Completed _____ ☐ High School/ GED ☐ College 2 yrs ☐ College 4 yrs ☐ Post Graduate	**Number of Children** ☐ N/A ☐ Children # _____	**Who lives in your current residents?** ☐ Self ☐ Spouse/Partner ☐ Others, List
Do you have any current home, work, social, or financial stressors affecting your life and well-being? ☐ No ☐ Yes, Please explain:	**How many hours of sleep do you get in a 24-hour period?** ☐ _____	**Hobbies/Recreation**	**Exercise** ☐ None ☐ Type and Frequency
Date of last Dental Exam **Date of last Vision Exam**	**Nutrition** **Are you happy with your current weight?** ☐ Yes ☐ No **Are you on a special diet?** ☐ No ☐ Yes, please list	**Do you eat 1-2 servings of fruits and 3-6 servings of vegetables daily?** ☐ No ☐ Yes	**How would you rate your overall nutrition?** ☐Excellent ☐ Good ☐ Fair ☐ Poor ☐ Terrible
		☐ High Blood Pressure	☐ High Blood Pressure

Tabacco/Alcohol/Caffeine/Drugs

Do you use Tobacco Products? ☐ Past User, Quit Date: _____ ☐ Current User ☐ Cigarettes # per day _____
☐ Cigars # per day _____ ☐ Vape # of cartridges day/week _____ ☐ Chewing tobacco, snuff, dips # per day _____
☐ Marijuana/Edibles amount per day _____

Do you use alcohol? ☐ No ☐ Yes, Frequency? ☐ Daily ☐ Social ☐ Rarely ☐ Binge
Type of Alcohol: ☐ Beer ☐ Liquor/Whiskey ☐ Wine ☐ Other _____
☐ # per day _____ ☐ # per week _____ ☐ # per month_____

Do you consume Caffeine? ☐ No ☐ Yes, Type ☐ Coffee, # cups per day _____ ☐ Tea, # cups per day _____
☐ Soda/Pop, # per day _____ ☐ Others _____, amount per day _____

Do you use Illicit Drugs? ☐ No ☐ Previous History ☐ Yes, current, **Type** ☐ Cocaine (Blow, Bump, Dust, Snow, etc.)
☐ Heroin (Smack, Horse, Hero, Brown, etc.) ☐ Methamphetamine (Speed, Crank, Chalk, Cookies, No Doze, etc.)
☐ Prescription Opioids or others ☐ Bath Salts ☐ Barbiturates (Barbs, Sleepers, Stumblers, yellow jackets, Dolls, tootsies, jackets, etc.)
☐ Benzodiazepines (Xanax, Ativan, Valium, Restoril, Benzos, Downers, poles, tranks, etc.) ☐ Others _____

Birthing Individual Only: Last Menstrual Period _____ Age of menstruation onset ____ Age of menopause _____
Are you pregnant? ☐ No ☐Yes: In prenatal care? ☐ No ☐ YES: Who is your provider? _____Due Date: ___/___/___
Problems with menstrual cycle: ☐ No problems ☐ Irregular ☐ Painful ☐ Heavy Bleeding ☐ No menses ☐ other _____
Number of Pregnancies _____ Number of Miscarriages ____ Number of Abortions _____ Current Birth Control _____
Date of last pap smear: _____ History of Abnormal Pap? ☐ No ☐ Yes
Last Mammogram Date: _____ Abnormal? ☐ No ☐ Yes

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Family Medical History		
Father: ☐ Living ☐ Deceased	**Age:**	**Cause of Death:**
Mother: ☐ Living ☐ Deceased	**Age**	**Cause of Death:**
Brothers # Living _____ # Deceased _____ age at death _____		**Cause of Death:**
Sisters # Living _____ # Deceased _____ age at death _____		**Cause of Death:**

Please mark any of the following for family members. (MGM-Mothers Mother, MGF-Mothers Father, PGM-Fathers Mother, PGF- Fathers Father)

High Blood Pressure:	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Diabetes	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Mental Illness **Type: _____**	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Glaucoma	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Osteoporosis	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Heart Disease **Type: _____**	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Stroke	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Bleeding Disorder **Type: _____**	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Alcoholism	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Thyroid Disease	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Cancer **Type: _____**	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father
Others **Explain: _____**	☐ MGM, Mothers Mother ☐ MGF, Mothers Father ☐ PGM, Fathers Mother ☐ PGF, Fathers Father

Consent for Medical Treatment

I consent to the medical staff of Sunshine Family Cares, Inc. to examine, obtain necessary lab work, treat, and counsel me. I understand that certain hazards and risks are connected with all forms of treatment and care, and with this knowledge, I give my consent. If I am treated for or diagnosed with a sexually transmitted infection, the clinic must report this to specific public health agencies. I understand that the law may also require clinic staff to report some claims of physical or sexual abuse. I certify that I have read and fully understand the above consent for testing and/or treatment. After evaluation, if my medical condition is beyond the capacity of SFC services, I will be referred elsewhere for further care. I have answered all the questions correctly to the best of my knowledge.

_____ _____ _____

Print Name of Patient Signature Date

Date Form Completed: ____/_____/_____

Financial Agreement/Office Policies/Notice of Privacy Practices/Consent for Treatment

Patient Name:_____ Date: _____

To the best of my knowledge, I have completed this form accurately and certify that I am the patient named above or the duly authorized general agent of the patient named above, authorized to furnish the information requested and seek and authorize health services. I hereby give my consent and authorize Sunshine Family Cares, Inc. to treat any medical health condition, providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition, and the care provider has discussed with me foreseeable risks of the above-stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment thought necessary during my visit should a condition be discovered that was not known previously.

I understand that Sunshine Family Cares, Inc. operates a primary care practice that integrates case management health services, which means case management health staff is part of my medical team and experience.

I have read and fully understand this Consent for Medical Treatment, and all my questions have been adequately answered.

Treatment, Payment, and Data Agreement

- I authorize examination and treatment for this and all following medical health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance, including a sliding scale fee program, is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize the release of all information necessary to secure benefits payments.
- I consent to Sunshine Family Cares, Inc. sending me one or more daily messages related to my health care. I understand data usage costs may apply based on my mobile carrier plan.
- I understand that Sunshine Family Cares, Inc. may use data developed for and/or provided by patients to determine the general characteristics of the communities it serves and that none of this information will in any way identify individual patients.

I certify that the above information is true and correct. I have received a copy of Sunshine Family Cares, Inc.'s Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature: _____ Date: _____

Legally authorized representative if not patient: _____ Date: _____

Relationship to Patient: _____

General Information: Informed consent from all patients accessing medical, behavioral health, and/or research services/activities will be obtained. Informed consent is not merely a signed document. It is an ongoing process considering patient needs and preferences, compliance with law and regulation, and patient education.

Staff Signature:_____ Date:_____