COMMUNITY OUTREACH MEDICAL CENTER
Bringing Community and Healthcare Together in Southern Nevada

## Health History Form

Name:_____ Birthdate:_____ Age:_____

Pharmacy Name/Location/Tel._____ Today's Date_____

What is your reason for this visit? _____

Current Gender Identity: ◯ Male ◯ Female ◯ Unknown

Sex at Birth: ☐ Male ☐ Female

☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM)

☐ Transgender (trans*, gender queer, gender non-conforming) ☐ Other: _____

Email Address: _____ Who/Where referred you to this clinic?_____

**Medical problems (past and present) & approximate date when diagnosed/first occurred**

| Condition | Date | Condition | Date | |
|---|---|---|---|---|
| 1. | | 5. | | |
| 2. | | 6. | | |
| 3. | | 7. | | |
| 4. | | 8. | | |

**Operations/Surgical procedures (include minor surgeries) & approximate date**

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**Hospitalizations (include reason for hospitalization, dates & where hospitalized)**

| Reason | Dates | Hospital | Reason | Dates | Hospital |
|---|---|---|---|---|---|
| 1. | | | 4. | | |
| 2. | | | 5. | | |
| 3. | | | 6. | | |
| | | | | | |

**Current medications, dose, instructions & approximate date started . Please include prescription, non-prescription & vitamins/herbal preparations (Please attach separate sheet if necessary)**

| Medication | Dose | Instructions | Date | Medication | Dose | Instructions | Date |
|---|---|---|---|---|---|---|---|
| *Ex. Atenolol* | *50 mg* | *1 daily* | *1/1/11* | 6. | | | |
| 1. | | | | 7. | | | |
| 2. | | | | 8. | | | |
| 3. | | | | 9. | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4. | | | | 10. | | | |
| 5. | | | | 11. | | | |

**Allergies to medications, food, or substance including type of reaction**

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| *Ex. Penicillin* | *Rash, Shortness of breath* | 3. | |
| 1. | | 4. | |
| 2. | | 5. | |

**Family History**

| | Father<br>Alive<br>Deceased | Current health conditions or cause of death | Mother<br>Alive<br>Deceased | Current health conditions or cause of death |
|---|---|---|---|---|
| Brothers | No. Alive | Current health conditions | No. Deceased | Cause of death |
| Sisters | No. Alive | Current health conditions | No. Deceased | Cause of death |
| Children | No. Alive | Current health conditions | No. Deceased | Cause of death |
| | Paternal<br>Grandparents<br>Alive<br>Deceased | Current health conditions or cause of death | Maternal<br>Grandparents<br>Alive<br>Deceased | Current health conditions or cause of death |

**Tobacco Use** Current smoker? ☐ YES ☐ NO If yes, how many packs/day?_____ For how long?_____

Have you ever smoked? ☐ YES ☐ NO If yes, year you quit_____

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**Alcohol Use** Do you drink alcohol? ☐ YES ☐ NO If yes, type: ☐ BEER ☐ WINE ☐ OTHER

Please indicate # of drinks and frequency: DAILY____WEEKLY____MONTHLY____YEARLY____

Have you ever needed treatment for alcohol abuse? ☐ YES ☐ NO

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**Recreational Drug Use** NONE List your drug(s) of choice:_____

Last Used: ◯ CURRENTLY ◯ W/IN 12 MONTHS ◯ W/IN 1-5 YRS ◯ MORE THAN 5 YRS

Have you ever needed treatment for drug abuse? YES ☐ NO ☐

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**Mental Health** Are you currently being treated for a mental health problem? YES ☐ NO ☐

Have you ever been emotionally or physically abused by your partner or someone important to you? YES ☐ NO ☐

During the past month, have you:

Been bothered by feeling down, depressed, or hopeless? YES ☐ NO ☐

Been hearing or seeing things that others don't see or hear? YES ☐ NO ☐

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**For Women** When was your last menstrual period? _____

Are your period's normal? YES☐ NO☐

Last normal period: _____

# of pregnancies: _____

# of living children: _____

Please check if it applies to you

Abortion ☐ If so, how many and when? _____

Miscarriage ☐ If so, how many and when? _____

_____

**Signature**

I certify that the information provided is correct to the best of my knowledge. I will not hold The Community Outreach Medical Center or any of its staff responsible for any errors or omissions that I may have made during the completion of this form.

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature | Date | COMC Staff Initials |

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**CLIENT INFORMATION**

**AND INFORMED CONSENT FORM**

Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security Number _____

Name of school if you are a student _____

Home/Cell Telephone _____ Work Telephone _____ Email: _____

**PLEASE CHECK ALL THE WAYS WE MAY CONTACT YOU**

Call home _____ Call work _____ Leave message with _____ Relationship _____

Mail plain envelope _____ Mail return address _____ Email:_____

Mailing address, if different from home address _____

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**PLEASE LIST WHOM TO CONTACT IN CASE OF EMERGENCY**
**(PARENT OR GUARDIAN IF UNDER 18)**

An emergency would be severe bleeding, unconsciousness, accident, or a condition requiring ambulance transport or hospitalization. Family Planning services **DO NOT** require parental permission; however, in an emergency situation, if you are under 18 years of age, we will notify a parent or guardian. Otherwise, no information about your care will be given to anyone without your knowledge and permission except as required by law.

Emergency Contact _____ Relationship _____

Street Address _____ Apartment Number _____

City _____ State _____ Zip Code _____

Place of employment _____

Home telephone _____ Work telephone _____ Message telephone _____

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I, _____, do hereby give my consent to the medical staff of Community Outreach Medical Center, to examine, obtain necessary lab work, treat, and counsel me. I understand that there are certain hazards and risks connected with all forms of treatment and care. With this knowledge, I give my consent. I understand that if tests are taken for sexually transmitted diseases, law may require reporting of positive results to public health agencies. I understand that the clinic staff is required by law to report any claims of physical or sexual abuse.

I hereby certify that I have read and fully understand the above consent for treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

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## Social Summary

Date _____ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widower ◯ **Male** ◯ **Female** ◯

Name _____
Last First Middle

Address _____
Apt # City Zip

Phone Number _____ Date of Birth _____ Age _____

Do you have insurance? _____ If yes, which one: _____

Do you live with your parents? _____ How many people do you support (Include yourself)? _____

Where do you work? _____
Indicate: Full Time ◯ Part Time ◯ On Call ◯

What is your gross monthly income (before taxes are taken out)? $_____
Do you receive any other source of income? (Alimony, SIIS, etc.) $_____

Where does your spouse work? _____
What is his/her gross monthly income (before taxes are taken out)? $_____

TOTAL MONTHLY INCOME (For All) $_____

**RACE / ETHNICITY:**

| | **RACE** Check only one | **ETHNICITY** Check if also Hispanic |
|---|---|---|
| A. American Indian or Alaska Native | ◯ | ◯ |
| B. Asian | ◯ | ◯ |
| C. Black or African American | ◯ | ◯ |
| D. Native Hawaiian or other Pacific Islander | ◯ | ◯ |
| E. White | ◯ | ◯ |

I AFFIRM THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THIS INFORMATION IS USED FOR STATISTICAL PURPOSES TO ASSIST IN GRANT WRITING JUSTIFICATIONS ONLY AND WILL BE KEPT CONFIDENTIAL.

SIGNATURE _____ DATE_____

## Consent for Treatment

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Community Outreach Medical Center will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that it is my responsibility to obtain all recommended testing, further evaluation, and follow up recommended by my physician/practitioner. I also understand that if tests are taken for certain communicable diseases, sexually transmitted infections/diseases, law may require reporting of positive results to relevant public health agencies.

I hereby release the Community Outreach Medical Center, its medical staff, and employees from any and all liability arising out of or connected with my lack of follow up recommended for any abnormalities identified.

I hereby consent to and request examination by the Community Outreach Medical Center and ensure that, to the best of my knowledge, all information submitted by me is true.

Signature of Patient/Legal Representative: _____ Date: _____

Relationship of Legally Authorized Representative to Patient: _____

**ACKNOWLEDGMENT OF**

**NOTICE OF PRIVACY PRACTICES**

**Our Notice of Privacy Practices explains how we may use and disclose protected health information about you. As provided in our Notice, the terms of our Notice may change. Copies of our Notice will always be available at our office and will reflect any updates we make to our Notice in the future. Please sign and date below to indicate that you have received a copy of the Community Outreach Medical Center Notice of Privacy Practices and an explanation of what it contains.**

_____

**Signature** **Date**

_____

**Printed Name**

**Please check:**

**Participant** ☐ **Parent** ☐ **Legal Guardian** ☐ **Personal Representative** ☐ **Agency** ☐

**Other**_____

**The following is to be completed by Community Outreach Medical Center personnel:**

Please check the applicable box:

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant signed this Acknowledgment.

☐ The Notice of Privacy Practices was offered and accepted by the participant and the participant refused to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered and refused by the participant and the participant agreed to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered to and refused by the participant and the participant refused to sign this Acknowledgment.

Staff Representative: _____Title:_____ Date:_____

## ZERO TOLERANCE POLICY

Community Outreach Medical Center, (COMC), strives to deliver the highest quality services to all its eligible clients/ patients and offers a comfortable/ safe environment in which to obtain services.

**We do however, reserve the right to suspend, alter or terminate a client's/patients Services/Privileges for any of the following:**

a. Threats and/or incidences of assault, theft, harassment, or abusive behavior towards COMC staff and or clients/patients

b. Providing falsified or fraudulent information in order to obtain services

c. Possession of weapons on COMC property, or COMC hosted events, used to intimidate or physically threaten client/ patients or staff. Weapons are defined as any object which could be used in a manner to threaten bodily harm.

d. Physical or verbal threats against other COMC clients/ patients or COMC staff members, destruction/ vandalism to COMC, or events having to do with COMC and/or COMC clients/patients

e. Sexual harassment/misconduct towards COMC staff and or clients/patients.

| Client Signature | Client UID/URD |
|---|---|

| Staff Representative | Title | Date |
|---|---|---|

## PATIENT RESPONSIBILITIES

The Community Outreach Medical Center relies on you to be an active participant in your healthcare and treatment so that we can provide the most effective healthcare for you. The following are your responsibilities. Please read & initial each carefully, so that you will understand our expectations of you.

| | |
|---|---|
| **Initials** | I will provide accurate and complete information about past & current health problems, hospitalizations, medications, treatment & any other matters relating to my health status. |
| **Initials** | I will let the staff know of any address, telephone number, or insurance changes I have. |
| **Initials** | If I do not understand something about my health problems, treatment, medications, their purpose, dosage and side effects, I will ask questions until I am satisfied I have enough information to make an informed decision. |
| **Initials** | I will bring *ALL* of my medication bottles with me to each of my appointments. These include (prescription, non-prescription, vitamin / herbal preparations. Please leave refrigerated medication at home). |
| **Initials** | My provider and I will discuss my treatment plan together and I will obtain ALL laboratory/radiology/diagnostic testing & follow up we agree I need. These tests will assist the provider make an accurate diagnosis of my condition and assist him/her to develop a treatment plan specifically me. Without my participation in my treatment plan, the provider will not be able to assist me to manage or resolve my health problems. |
| **Initials** | I understand that I will be provided with enough medication to last until my next appointment, and that I will obtain prescription refills at my follow up appointment. |
| **Initials** | I understand that I am responsible for finding out my test results as instructed by clinic staff, at my follow up appointment. |
| **Initials** | I will pay for all services provided to me before leaving the clinic. |
| **Initials** | I will be respectful and considerate to all clinic staff, fellow patients, clinic property, follow clinic rules and make sure that any persons with me will also comply. |
| **Initials** | I understand I am never to attend a visit with COMC staff under the influence of any substance, including narcotics or controlled substance, which can alter my ability to comprehend or that can compromise my judgment. |

I fully understand and will comply with my patient responsibilities at Community Outreach Medical Center.

| _____ | _____ | _____ |
|---|---|---|
| Patient signature | Signature of legal authorized representative | Date |

***For patients eligible for services provided by the Ryan White program, there may be certain responsibilities listed above that may not apply to you. Please ask staff if you have any questions.

## CLINIC POLICIES

We are happy you have chosen our clinic for your healthcare needs. The Community Outreach Medical Center strives to provide the best care for our patients, and desires to make your interactions with us both pleasant & productive. We feel that we can better serve your healthcare needs if you are familiar with the following policies & procedures of the clinic, and by following the instructions that we have provided.

**Office Hours:** Our office is open Monday – Friday from 8:00am to 5:00pm. We are closed between 12:00pm to 1:00pm for lunch, weekends & holidays. We do not provide emergency care, urgent care nor are we a quick care. If you need these services, please call 911 for Emergency Care or Information (411) for an Urgent/Quick care close to you.

**Appointments:** Please call (702) 657-3873 to schedule an appointment. Patients are seen by appointment only. We ask that you call at least 48 hours in advance if you need to cancel or reschedule your appointment.

**Payment for services:** Payment for services is due in full at the time of service. Community Outreach Medical Center does not bill for any services (except for those individuals referred by certain agencies with whom we have an agreement). We accept credit/debit cards and cash for payment. **WE DO NOT ACCEPT CHECKS OF ANY KIND FOR PAYMENT OF SERVICES.**

**Medical Records:** We will need a minimum of seven (7) business days to process your request for medical records. A current Release Of Information must be completed/signed by you in order for us to process your request. In addition, as Nevada Revised statutes allows us to charge a minimal processing fee for this service, you may be charged accordingly and expected to pay before the records are released.

**Forms for completion:** As a number of our healthcare providers work at the clinic part time**, w**e will need a minimum of (fourteen) 14 business days to process your request for the completion of letters for verification of medical conditions, disability, FMLA, etc., forms. There will be a fee charged to you prior to releasing the completed forms to you. This fee is based on the number of pages we are required to complete.

**Prescription refills:** Due to the overwhelming amount of time our staff spends managing prescription refills, the clinic will be providing prescription refills at your follow up appointment ONLY. (For patients in certain programs who have kept follow-up appointments, have had lab work, diagnostic tests completed as ordered, have your pharmacy fax a refill request AT LEAST 2 WEEKS before your prescription runs out. WE ARE NO LONGER ABLE TO COMPLETE/FAX REFILL REQUESTS ON THE SAME DAY AS THEY ARE RECEIVED. PLAN ACCORDINGLY).

**Test Results:** ***DO NOT call the clinic for your results or to ask if they are in***. ***Your results*** will be discussed with you at your follow up appointment or by letter (for applicable patients only). If you are awaiting a result letter & have not received it in 2 weeks from the date of your test, please call the clinic to inform us. If you are picking up your letter, then you may do so no earlier than 2 weeks after your test was done. Please allow 2 weeks for us to receive your results.

***For patients eligible for services provided by the Ryan White Program, certain policies (regarding payment/fees) may not apply to you. Please ask clinic staff if there are any questions.

**Nurse Call Backs:** **N**urses will have a minimum of 48 hours to return your phone calls. Please remember that they have many responsibilities in the clinic and cannot stop to take your calls. When you want the nurse to return your call, be sure and provide the receptionist with a telephone number where you will answer when the nurse calls. If you are not available when the nurse calls, your call will drop to the bottom of the nurses' call back list and you will not be contacted again for 48 hours.