WELLSPACE HEALTH
Comprehensive care since 1953

PATIENT/CLIENT REGISTRATION FORM

Today's date:___________________________

Last Name	**First Name**	**Middle Name**
Other names used	**Date of Birth**	
Social Security Number		

Current Gender
☐ Male ☐ Female ☐ Transgender
☐ Decline to answer

Sexual Orientation
☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual ☐ Bisexual
☐ Something else
☐ Decline to answer ☐ Don't know

Gender Identity
☐ Male ☐ Female
☐ Female to Male (FTM)/Transgender Male/Trans Man
☐ Male to Female (MTF)/Transgender Female/Trans Female
☐ Gender Queer (neither exclusively male nor female)
☐ Additional Gender Category
☐ Something else
☐ Decline to answer

Preferred Pronoun
☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other ☐ Decline to answer

Physical Address

Street Address

City State Zip Code

Mailing Address (check here if same as above) ☐

Street or P.O. Box

City State Zip Code

Contact Information ☐ Ok to leave message ☐ Do not leave massage
Home Phone

Cell Phone ☐ Ok to leave message ☐ Do not leave message

Email: (check here if OK to use this email to enroll in Patient Portal) ☐

Language
☐ American Sign ☐Chinese ☐ English ☐ Hmong ☐ Japanese ☐ Punjabi ☐ Spanish ☐ Russian
☐ Tagalog ☐ Vietnamese ☐ Other____

Religion
☐ Buddhist ☐ Catholic ☐ Christian ☐ Eastern Orthodox ☐ Hindu ☐ Islamic ☐ Jehovah's Witness
☐ Mormon ☐ Unitarian ☐ None ☐ Other____

Marital Status

☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

☐ Other____

Are you a student?

☐ No ☐ Yes, full-time ☐ Yes, part-time

Are you a veteran?

☐ No ☐ Yes

Have you been homeless at any time since January of this year?

☐ No

☐ Yes, doubling up/couch surfing ☐ Yes, shelter ☐ Yes, on the street ☐ Yes, transitional housing

☐ Yes, other: ____

Racial Background (check all that apply)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Filipino

☐ Hispanic or Latino ☐ Native Pacific Islander ☐ Other Pacific Islander ☐ White

☐ Other____

Are you Hispanic or Latino?

☐ No ☐ Yes

Are you a migrant worker?

☐ No, not a farm worker ☐ Yes, Migrant ☐ Yes, Seasonal worker

Are you Head of Household?

☐ Yes, Self ☐ No, Other Person ______________________________

# of persons in your family ____________________

Family income $____________________________ ☐ Annually ☐ Monthly ☐ Weekly

Emergency Contact

Name

Phone | Relationship

Would you like assistance during your appointment?

☐ No, thank you ☐ Yes, language interpreter ☐ Yes, low vision/blindness ☐ Yes, mobility assistance

☐ Yes, Other____

Patient/Client Agreement

- The information I have given is true to the best of my knowledge.
- By signing below I am consenting to receiving medical, dental, and/or behavioral health services from WellSpace Health either in person or via telehealth, including immunizations (or am consenting for the minor in my care).
- I acknowledge WellSpace Health provides clinical training opportunities to students who may be present during my visit.
- I acknowledge my responsibility to pay for services according to the policies established by WellSpace Health.
- I authorize assignment of benefits for services to be paid to WellSpace Health.

____

Patient/Client Signature (or Parent/Guardian of Patient Signature) **Date**

WELLSPACE HEALTH
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Patient/Client Rights

Welcome to WellSpace Health! We are dedicated to providing you with high quality medical, dental, and behavioral health services. The safety of patients/clients is enhanced when patients/clients are partners in the health care process. Please review the following information carefully. If you have a question about the following information, please ask a staff member for assistance.

Access to Care:

You have the right to:

1. Access to care without regard to gender, sexual orientation, culture, economics, education, religion, language, age, race, color, ancestry, national origin, presence of a disability, or the source of payment for your care.
2. Obtain a reasonable response to any reasonable request made for services within the Health Center's capacity, stated mission, applicable laws, policies, and regulations. The Health Center will give each patient/client necessary health services to the best of its ability, including choice of Provider.
3. Information how to appropriately access urgent or emergency services.
4. Information how to seek a second opinion and seek specialty care.

Considerate and Respectful Care:

You have the right to:

1. Considerate, respectful care and treatment that optimizes your comfort and dignity.
2. Appropriate care which reflects your values, beliefs, or preferences while acknowledging legal limitations, policy limitations, physical limitations, and psychosocial, spiritual, and/or cultural concerns.
3. Reasonable continuity of care and knowledge in advance of the time and location of future appointments, as well as the identity of the Provider providing that care.
4. Expect that as Mandated Reporters, all allegations, observations, and suspected cases of neglect, exploitation, and abuse will be reported to the appropriate authorities.
5. Request that any Provider or staff member wash their hands prior to giving care.

Knowledge and Information about your Care:

You have the right to:

1. Request to see the staff identification of the Provider who has primary responsibility for coordinating your care and other health professionals who will treat you.
2. Receive information from the Provider about your care and treatment in terms that you can understand.
3. Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment.
4. Receive information in a form that is easy to understand and is complete, accurate, timely, and unambiguous to enable you to give informed consent, including interpretation if needed.
5. Refuse care, treatment, or services.

Active Participation in your Care:

You have the right to:

1. Actively participate with your Provider in making decisions regarding your care.
2. Formulate advance directives.
3. Participate in end-of-life decisions.

Health Insurance Portability and Accountability Act (HIPAA) & Confidentiality:

You have the right to :

1. Ask to see and/or get a copy of your health records. A request must be made in writing and WellSpace Health will have 10 business days to process a request.
2. Have corrections added- but not replaced- to your health information.
3. Receive a notice that tells you how your health information may be used or shared.
4. Decide if you want to give your permission before your health information, recordings, films, or images can be used or shared for certain purposes, such as marketing.
5. Get a report on when and why your health information was shared for certain purposes.

Respect for Patient Rights regarding your Care:

You have the right to:

1. Respectfully and appropriately express concerns or complaints about your care with the assurance that the presentation of a concern will not compromise the quality of your care or future access to care, and to expect a reasonable and timely response to your concerns.
2. Expect that all WellSpace Health personnel shall observe these patient rights and that all patient rights apply to the person who may have legal responsibility to make decisions regarding care on your behalf.

Appoint a surrogate decision maker for your Care:

You have the right to:

1. Appoint a surrogate decision maker for your care, who will have all the same rights and responsibilities as the patient/client. A written form must be on file with WellSpace Health regarding surrogate decision makers and the situations in which they would be empowered to make decisions on your behalf.
2. Expect that when the term patient/client is used in this form, it means that if the patient/client is unable to make decisions, the surrogate decision maker will do so.

If you believe your rights are being denied or your health information isn't being protected, you can file a complaint with WellSpace Health Administration, and/or your health insurer.

I have read and understand the above information. I have had an opportunity to ask WellSpace Health staff for help with understanding each item. I will be provided a copy of these Patient/Client Rights.

Print Patient/Client Name ____ Date ________

Patient/Client Signature (or Parent/Guardian Signature) _______________________________ Date ________

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Terms and Conditions

Welcome to WellSpace Health! We are dedicated to providing you with high quality medical, dental, and behavioral health services. Please review the following information carefully, and initial each statement to indicate you understand each statement. If you have a question about the following information, please ask a staff member for assistance

________ Initial

Health Center Hours

WellSpace Health Centers are open Monday through Friday, 8am to 5pm, or as otherwise indicated.

- During regular Health Center hours, call 916-737-5555 to speak with your care team.
  - In case of a medical emergency, please call 911.
- If you have a *medical need* outside of normal Health Center hours, please call 916-737-5555 to be connected to the after-hours service.
- If you have a *women's health need* outside of normal Health Center hours please call 916-392-2290 to be connected to the after-hours service.
- If you have a pediatric *dental need* outside normal Health Center, hours please call 916-822-8958 to be connected to the after-hours service.
- If you have a *behavioral health need* outside of normal Health Center hours, please call:
  - Contact WellSpace Health's 24hr Suicide Prevention Crisis Line at 916-368-3111 or 1-800-273-8255.
  - Go to your local Hospital Emergency Room
  - Call 911 and ask to speak to the mental health worker on call.

________ Initial

Check In for Appointments

- We ask that you please arrive at your scheduled time for your appointment.

________ Initial

Missed Appointments

- WellSpace Health serves thousands of patients/clients every month. In order to best serve you, we ask that you provide WellSpace Health 24-hour advance notice to cancel a scheduled appointment so that we may offer that appointment to another patient/client. Failure to provide advance notice will be considered a "missed appointment". Patients/clients who miss 3 consecutive appointments in a 6 month period may only be seen by Open Access for 6 months from the 3rd missed appointment date.

________ Initial

Children's Appointments

- A parent or legal guardian or other adult must accompany minor children to all appointments. If you are a minor seeking treatment without a parent or guardian, see a staff member for additional paperwork.

________ Initial

Medical Records

- The records, x-rays, photographs, models, and other materials relating to your treatment, or the treatment of your child, are the property of WellSpace Health. You have the right to request copies in writing. Please allow up to 10 business days to process your request. The patient/client, or parent or guardian, must sign a Release of Information before duplicate records can be sent to another health care provider.

________ Initial

Address/Phone Number Changes Notifications

- It is important for us to reach you to confirm appointments, provide test results, or to follow-up on your visit. To that end, we ask that you update us with any changes in your phone number or address or email address at each appointment.

________ Initial

Refill Requests

- **Contact your pharmacy directly for refill requests.** Please allow up to 72 hours for processing of prescription refill requests from your pharmacy. If you will need an appointment before refills are ordered, please call for an appointment at least 2 weeks before you run out of medication. In addition, bring your medication bottles with you to each appointment.

________ Initial

Exam and Treatment Rooms

- Cell phones must be silenced at all times. Please do not make or take calls/texts unless in case of an emergency. Children receiving care may be accompanied by one person. No food or beverage allowed.

________ Initial

Pain Policy

- WellSpace Health follows nationally accepted medication prescribing guidelines. Your current prescriptions will be reviewed by your provider. If the provider believes an alternate medication is appropriate, your medications may be changed. All patients/clients receiving controlled substances will be asked to sign a Pain Medication Agreement. Our refill policy is explained in the Pain Medication Agreement. Narcotics are not prescribed on the first appointment.

______ Initial

Photographs
- Patient/client photographs may be taken at initial and annual visits for patient's chart, as well as to document clinical conditions or findings, and to help provide extraordinary customer service. Any other uses require written consent from the patient/client, or parent or guardian.

______ Initial

Personal Conduct
- It is our expectation that all patients/clients and staff at WellSpace Health will be treated with dignity and respect. If you do not follow this policy, you may be asked to leave. Examples of behavior that could lead to termination of your care with WellSpace Health include, but are not limited to:
  - Yelling at, harassing, or threatening other patients, staff, or visitors
  - Removing supplies, equipment, Health Center property, or WellSpace Health staff property
  - Public intoxication (including alcohol and/or drugs)
  - Vulgar or offensive language
  - Failure to comply with WellSpace Health policies or staff directions

______ Initial

Medical Providers
- All or part of your medical care at this Health Center will be provided either by a Nurse Practitioner (NP) or Physician Assistant (PA) and is supervised by a physician. The quality of your care will be the same as if you were evaluated and/or treated by a physician. If you do not feel that this is so, and/or you are dissatisfied with the care of the NP or PA, please ask for an appointment to speak with the Health Center manager. Any patient has the right to refuse treatment by a NP or PA and can request to be seen by a physician. Understand that you may not be able to have an appointment with a physician that same day, but you are not being refused treatment today by the NP or PA. Well Space Health provides clinical training opportunities to students including physicians, physician assistants, nurse practitioners, behavior health providers and allied health staff who may be involved in your care.

______ Initial

Telehealth Appointment
- Your visit may be conducted via telehealth. Telehealth is a way to connect with your provider by phone or video. Telehealth offers you the same level of care as if you were in person with your provider at the health center. Your care team will inform you if your visit is eligible for telehealth. You have the right to decline a telehealth visit.

______ Initial

Take Responsibility for your Care

You have the **responsibility** to:
- Inform your Provider about your health history, current medications, and to fully participate in self-management activities.
- Inform staff about any phone, address, email address, or insurance changes as soon as they happen.
- Ask questions if you have any concerns or are unclear about any aspect of your care.
- Follow instructions regarding your care plan, treatment, or services. If instructions are not followed, understand that there are health consequences if your care plan, treatment, or services are not fully followed.

______ Initial

Payment and Collection
- I understand that I am financially and legally responsible to pay for services that I, or the minor in my care, receive at WellSpace Health.
- I also understand that financial counseling is available to help qualify for government-sponsored programs, establish a payment plan, and charity care.
- I understand I am responsible for any balance due of any treatment that my insurance or any other program does not cover/pay for.
- I also understand payment is due on day of service unless a financial arrangement is made.
- I authorize the release of any medical or other information necessary to process the claims. I assign and authorize payments from all sources to WellSpace Health for my treatment.

I have read, understand, and agree to follow the above policies. I have had an opportunity to ask WellSpace Health staff for help with understanding each policy. I give my consent to WellSpace Health to evaluate, screen, treat, and render services to me (or the minor in my care listed below). I will be provided a copy of these Terms and Conditions of Services.

____

Print Patient/Client Name Date

____

Patient/Client Signature (or Parent/Guardian Signature) Date

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Adult Medical History Form

Today's Date:____

Name:____ Date of Birth____________________________

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.		
Medication/Vitamin/Supplement (i.e. Atenolol)	**Dose/Strength (e.g. 50mg)**	**How many times per day (i.e. once per day)**

ALLERGIES: Do you have allergies or reactions to:	
Medications	**Reaction**

Surgical History		
Surgeries:	Year of Surgery	Reason for Surgery
1.		
2.		
3.		
4.		

PERSONAL HISTORY: Have you ever had problems with any of the following conditions:					
	Yes	**No**		**Yes**	**No**
Heart disease	☐	☐	Sickle cell disease	☐	☐
High blood pressure	☐	☐	Kidney/bladder problems	☐	☐
Stroke	☐	☐	Seizures/epilepsy	☐	☐
Diabetes	☐	☐	Depression	☐	☐
High Cholesterol	☐	☐	Suicidal thoughts	☐	☐
Tuberculosis	☐	☐	Mental illness	☐	☐
Asthma		☐	Severe headaches or migraines	☐	☐
Blood clot in legs/lung			Liver problems or hepatitis	☐	☐
Bleed/bruise easily			Gallbladder disease	☐	☐
Anemia			Eating disorder	☐	☐
Cancer Type:____________			Thyroid Disease	☐	☐
Fibroids (women only)	☐		Ovarian cyst/abnormality (women only)	☐	☐
Other Medical Conditions			Prostate Disorder	☐	☐

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Adult Medical History Form

WOMEN'S HEALTH

Number of pregnancies________
Number of live births________
Number of abortions________
Number of miscarriages________
Number of ectopic (tubal) pregnancies________

When was your last pap smear? _______
I have never had a pap smear______
Have you ever had an abnormal pap smear?
❑ No ❑ Yes If yes, when? _______________

First day of last period____ Periods come every_days and last___________________days
Periods are ❑ Regular ❑ Irregular ❑ Painful ❑ Light ❑ Moderate ❑ Heavy
Do you have spotting or bleeding between periods?
❑ No ❑ Yes

Have you ever had a mammogram?
❑ No ❑ Yes
If yes, when was your last one? _________
Was it normal? _________

MEN'S HEALTH

When was your last genital exam?________❑ Never had

Habit and Lifestyle

Tobacco Use
Cigarettes: ☐ Never Quit Date____________ Current Smoker: packs/day _____ # of yrs ________
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew ❑ Vaping Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use
Do you drink alcohol? ❑ No ❑ Yes # drinks/week _____
Is your alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use
Do you use street drugs? If yes, please list:_____________________________________
4. Have you ever used injectable drugs? ❑ No ❑ Yes
5. Have you ever shared needles? ❑ No ❑ Yes
6. Has anyone ever told you that you have a problem with drugs or alcohol? ❑ No ❑ Yes

Have you ever had an HIV test? ❑ No ❑ Yes if yes, when?________What were the results? __________

Have you ever had a Hepatitis C test? ❑ No ❑ Yes if yes, when?________What were the results? ______

Immunizations	Health Maintenance
Date of your last flu shot: ________________	Date of your last physical: ______________________
Date of your last pneumonia shot: _______________	Date of your last colonoscopy: ________________
Date of your last tetanus shot: _________________	

DENTAL HISTORY

Date of last dental visit_____________ Date of last x-rays ________________
History of injury to teeth or jaws: ❑ No ❑ Yes Describe:_______________________________________
History of dental pain: ❑ No ❑ Yes
History of dental infections: ❑ No ❑ Yes

____
Signature of person completing the form Date

____
Provider Signature Date