AVIVA HEALTH

Adult Health History

Name:_____ **DOB:**_____ **Date:**_____

Please list medications, including: vitamins, herbs, homeopathic remedies, and nonprescription medicines on the attached medication sheet.

Medical History:

☐High blood pressure	☐Heart attack	☐Asthma	☐Emphysema/bronchiti
☐High cholesterol	☐Cancer	☐HIV/AIDS	☐Thyroid problems
☐Mental illness	☐Stomach ulcer	☐Diabetes	☐Hepatitis A/B/C
☐Alcoholism/addictio	☐Migraine	☐Tuberculosis	☐Blood transfusions
☐Other			

Hospitalizations (not surgery):_____

Surgeries:_____

Serious injuries and automobile accidents:_____

Occupation:_____ **Who do you live with:**_____

Family History: Answer for parents, brothers, sisters, grandparents: ☐Unknown
☐Alcoholism_____ ☐Heart Disease_____ ☐Asthma_____
☐High blood pressure_____ ☐Cancer_____ ☐Mental Illness_____
☐Diabetes_____ ☐Stroke_____ ☐Lung Disease_____
☐Other_____

Women's Health: Age at first period_____ Date of last period_____ Year of last Pap_____
Result of Pap_____ Year of last mamo_____ Result_____
Birth control used now_____ Number of pregnancies_ Births_____

Immunizations: ☐All childhood shots Last tetanus ____ Last Influenza__ Last Pneumonia_____
Hepatitis A___ Hepatitis B____ Last skin test for TB____ Reaction to TB test: ☐Pos ☐Neg

Tobacco Use: Cigarettes ☐ Yes ☐ No Year Started_____ Year Stopped__ Avg amt_____

Chew/snuff ☐ Yes ☐ No Year Started_____ Year Stopped__ Avg amt_____

Alcohol Use: ☐Never ☐Daily ☐Weekly ☐Monthly ☐Less than monthly

Other Drugs: ☐Never ☐Daily ☐Weekly ☐Monthly ☐Less than monthly Ever IV? ☐No ☐Yes
☐Marijuana ☐Methamphetamine (crank/speed) ☐Cocaine ☐Heroin ☐Other

Signature:_____ **Date:**_____

Provider Signature:_____ **Date:**_____

AVIVA HEALTH

Medication Worksheet

Name:_____ **DOB:**_____ **Date:**_____

Medication Name	Strength	Frequency	Reason for Taking
Example: Lisinopril	1-mg	Once a day	High blood pressure

Annual Patient Update Packet

By marking yes to special confidentiality, you are stating that if your partner/spouse or parent/guardian were to receive a bill or phone call from this clinic about your appointment today, you would worry about your safety. Special confidentiality is not pertaining to your medical records. ☐No ☐Yes

Patient's Name:_____Middle:_____ Last:_____
Date of Birth:_____Age:_____Marital status:_____Sex: Male Female
Patient's SSN:_____Cell:_____Home:_____Work:_____
Email:_____Are you signed up with the Patient Portal:_____
Responsible Party:_____Date of Birth:_____
Mailing Address:_____City:_____Zip:_____
Physical Address: _____
Employed? Yes No Employer:_____Full time Part-time Seasonal/Temp
Student? Yes No Status: Full time Part time
Agricultural Work Status: migratory seasonal none
Emergency contact:_____ Phone:_____

Insurance Coverage: OHP Medicaid Medicare Commercial Insurance None
Primary Insurance: _____
Policy Holder: _____Relation to patient:_____Date of birth_____
ID#_____ Group #_____Employer:_____
Secondary Insurance: _____
Policy Holder: _____Relation to patient:_____Date of birth_____
ID#_____ Group #: _____ Employer: _____

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, including mental health issues, HIV/AIDS related records, appointment scheduling, or payment information. This is not a release for medical records. This is only for permission to speak with desigated family or personal representatives.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Please write a date that you are giving the above-named people permission to discuss your medical information or initial on lifetime line.

Authorization period: FROM:_____TO:_____ OR LIFETIME: _____

Patient Signature (legal guardian):_____Date:_____

The following information is needed to assist the clinic in securing funds. Your cooperation is appreciated. <u>All information disclosed in this section is reported anonymously and will not impact access to care</u>.

Please circle the correct amount or check the box if monthly income is above all amounts.

Number of Persons in Household	1	2	3	4	5	6
Household Income is Less Than	1,074	1,452	1,830	2,209	2,587	2,965
Household Income is Less Than	1,611	2,178	2,745	3,314	3,880	4,448
Household Income is Less Than	2,148	2,903	3,660	4,418	5,173	5,930
Income is Above all amounts	☐	☐	☐	☐	☐	☐

☐ Choose not to provide my financial information.

Have you ever been in the military? Yes No **Have you been seen at the VA?** Yes No
US citizenship: By Birth Permanent Resident/Alien Student Visa Other
Ethnicity: Hispanic Non-Hispanic Choose not to disclose
Race: Black White Asian American Indian Pacific Islander Hawaiian Other
Language Spoken: _____ **Do you need a translator?** Yes No
Are you: a single parent? Yes No **Homeless?** Yes No **Resident of public housing?** Yes No
Gender Identity: Male Female Transgender Male Transgender Female Other Choose not to disclose
Sexual Orientation: Straight Lesbian/gay Bisexual Other Don't know Choose not to disclose

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Aviva Health, to render needed treatment to the above named patient.
2. I authorize Aviva Health to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to Aviva Health for services rendered.
4. I understand that I am responsible for all charges incurred through Aviva Health.

I request that payment under the medical Insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If it becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature of applicant:_____ **Date:**_____

Signature Parent/Guardian_____ **Date:**_____

Staff initials/Date:_____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____ have received a copy of Aviva Health's notice of Privacy Practices.

_____

(Signature of patient or legal guardian) (Printed patient or legal guardian)

Date:_____

For Internal Purposes Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

-Individual refused to sign.
-Communication barriers prohibited obtaining acknowledgement.
-An emergency situation prevents us from obtaining acknowledgement.
-Other (please specify):_____

Office Policies

MAKING APPOINTMENTS: Please be as specific as possible regarding your area of concern. This will help us to schedule the proper amount of time necessary for your care.

MISSING APPOINTMENTS: Please notify the Clinic as soon as possible if you are unable to keep your appointment. Canceling appointments less than 24 hours in advance could result in a "no show." This also includes referral appointments to outside clinics, physicians, and walking out on your appointment. Our answering service is available 7 days a week, 24 hours a day for your convenience. Please notify us if your scheduled appointment time needs to be changed. This allows for someone else who is waiting to be seen.

BEING LATE FOR APPOINTMENTS: Please be at least **10 minutes early for your routine appointments and 30 minutes early for new patient appointments**. This will ensure staff has time to input your information into your chart. Your appointment time is an allotted time. _____**(Patient or responsible party initials)**

LAB AND X-RAY REPORTS: Your lab and x-ray results are part of the total picture of your health and must be analyzed by your health care provider in light of your history and physical exam. When you have a lab or x-ray there will be additional charges that you are responsible for. Please check with that office before you have the services. You will be notified of your results, or your provider will discuss your results at your follow-up visit. **Please allow up to 2 weeks for this process.**

PRESCRIPTION REFLL POLICY: Please call your pharmacy and request a refill, even if it states "no refill" they will notify us. **Please give us 48 to 72 hours to process your refill.** We will review your chart and notify the pharmacy of the practitioner's decision. Please notify the pharmacy 1 week before your meds are finished. **It is your responsibility to monitor the amount of medication you have.**

REFERRALS FOR OREGON HEALTH PLAN PATIENTS: The Oregon Health Plan requires us to submit a request for referral when the practitioner orders a specialist consult. The process can take up to 1 week or sometimes longer. We will contact you when this process has been completed and instruct you to call the specialist to make your appointment. Please be patient. It takes time to get the approval.

PAYMENTS: Payments are expected at the time of service. You will be told what your minimum expected amount will be for each appointment. The amount could be more according to the procedures done. If you are unable to pay at the time of your visit your appointment may need to be rescheduled. _____(Patient or responsible party initials)

I have read the above and agree to the terms provided.

Signature:_____Date:_____