Coast Community Health Center

Your Health ~ Our Mission

Our Mission at Coast Community Health Center is to increase the access and availability of affordable, quality, primary and preventative health care for all.

Please return the completed packet to our health center either by mail or drop it off in person.

BANDON	PORT ORFORD
1010 FIRST ST SE, SUITE 110 BANDON, OR 97411 541-347-2529 541-347-9196 (fax) HEALTH CENTER HOURS Monday-Thursday 8 am – 6 pm Friday 8 am – 5 pm www.coastcommunityhealth.org	**PHYSICAL ADDRESS:** 1312 TICHENOR ST PORT ORFORD, OR 97465 541-332-1114 541-347-9196 (fax) HEALTH CENTER HOURS Monday 8 am – 5:30 pm Tuesday-Thursday 7 am – 5:30 pm Friday 7 am – 5 pm www.coastcommunityhealth.org **MAILING ADDRESS:** 1010 FIRST ST SE, STE 110, BANDON, OR 97411

Lab services available Monday – Friday. Ask your patient services representative for available times.

After Hours services are available by calling the Health Center at 541-347-2529.

The staff and leadership of Coast Community Health Center look forward to meeting you and your family! Please feel free to call the Health Center with any questions you may have.

Best regards from all of us!

Coast Community Health Center

Patient Registration Form *Your Health ~ Our Mission*

Patient Demographic Information

Last Name	**First Name**	**M.I.**	**Preferred Name**

Date of Birth	**Sex at Birth** □ Male □ Female	**Mailing Address**	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Physical Address**	**City**	**State**	**Zip**

Social Security Number	**Email Address**

Do you have an Advance Directive/Living Will/Power of Attorney? Yes □ No □	**Patient Marital Status** □ Divorced □ Married □ Single □ Widowed □ Domestic partner □ Separated
Primary Care Provider (Medical)	**Preferred Pharmacy**

Patient Emergency Contact Information

Emergency Contact Name	**Relationship to Patient**	**Phone Number**	**HIPAA?** □ **Yes** □ **No**
Secondary Contact Name (Optional)	**Relationship to Patient**	**Phone Number**	**HIPAA?** □ **Yes** □ **No**

Patient Structured Data Information

Coast Community Health Center receives grant funding based on the following questions. Your answers will remain private and contribute to Coast Community Health Center providing higher quality healthcare services.

What is your household annual income? _____ *This is used to assess your need for, and ability to qualify for, financial assistance programs.* **How many people in your family?** (Yourself, spouse/partner, and minor children under 18 years) _____ **Are you in need of financial assistance YES □ NO □**		**Veteran Status:** □ Veteran □ Not a veteran □ Choose not to disclose	**Homeless Status:** □ **Yes** □ **No** □ Shelter □ Street □ Transitional Housing □ Doubling up
		Agricultural Status over the last 3 years: □ None □ Migrant □ Seasonal □ Choose not to disclose	**Student Status:** □ Student full time □ Student part time □ Not a student
Employment Status: □ Employed full time □ Employed part time □ Unemployed □ Retired □ Disabled □ Choose not to disclose	**What pronouns do you use?** □ he/him □ she/her □ they/them □ Other _____ □ Choose not to disclose	**Do you think of yourself as:** □ Lesbian or Gay □ Straight (Not lesbian or gay) □ Bisexual □ Something else □ Don't know □ Choose not to disclose	**What is your gender identity?** □ Male □ Female □ Transgender Male □ Transgender Female □ Non-Binary/Gender Fluid □ Choose not to disclose
Racial Group(s): □ African American/Black □ Asian □ Caucasian/White □ Native American □ Alaskan Native □ Pacific Islander □ Native Hawaiian □ Other: □ Choose not to disclose	**Ethnicity:** □ Hispanic/Latino/Latina □ Non-Hispanic, Latino, Latina □ Choose not to disclose	**Do you want to sign up for MyChart** (patient online portal)**:** □ Yes □ No	**Preferred Language:** _____ **Do you need an Interpreter?** □ Yes □ No

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Responsible Party Information		
Responsible Party Name	**Responsible Party Employer**	**Responsible Party Social Security #**
Mailing Address City State Zip	**Patient's Relation to Responsible Party** □ Self □ Child □ Spouse □ Parent/Guardian □ Other (please list) _____	
Date of Birth	**Phone Number**	**Sex:** □ Male □ Female
Are you self-pay or uninsured? □ **Yes** □ **No** **If yes, skip to Clinical History Form**		
Primary Insurance Company	**Policy/Member ID #**	**Policy Group#**
Policy Holder Name □ Same as above	**Policy Holder DOB** □ Same as above	**Policy Holder Social Security Number** □ Same as above
Secondary Insurance Company □ N/A	**Policy/Member ID**	**Policy Group#**
Policy Holder Name □ Same as above	**Policy Holder DOB** □ Same as above	**Policy Holder Social Security Number** □ Same as above

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Clinical History Form		
Patient Name	**Age**	**DOB**
Previous Medical Provider(s)		
Your complete medication history is important. Patients are required to update this list for accuracy at each appointment. Please bring all medications you are taking, in their original containers, to your first appointment.		

Patient Allergy Information			
Are you allergic to medications, iodine, shellfish, food, tape, or latex?		**□ Yes**	**□ No**
Allergy	**Reaction**	**Allergy**	**Reaction**
□ No Known Allergies			

Current Medications: List all prescriptions, non-prescriptions, and over the counter (OTC) medications and supplements that you currently take. Please include any herbals, eye drops, nutritional supplements, inhalers, ointments, etc.		
Medication	**Dose**	**Frequency**

Past Surgical History:			
Date	**Operation/Procedure**	**Reason**	**Hospital/Facility**

Immunizations:			
Date	**Immunization**	**Date**	**Immunization**

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Preventive History:			
Screening	**Date**	**Screening**	**Date**
Colonoscopy		**Mammogram**	
Cologuard		**Pap Smear**	
FIT Test		**Influenza Vaccine**	
DEXA/Bone Density Scan		**Pneumonia Vaccine**	
COVID-19 Vaccine		**COVID-19 Vaccine (2nd dose)**	

Significant Family History: Check any family member who has suffered or experienced any of the following conditions							
Condition	**Mother**	**Father**	**Sister(s)**	**Brother (s)**	**Child(ren)**	**Grandmother** □ Maternal □ Paternal	**Grandfather** □ Maternal □ Paternal
Arthritis						□ Maternal □ Paternal	□ Maternal □ Paternal
Heart Disease						□ Maternal □ Paternal	□ Maternal □ Paternal
Depression						□ Maternal □ Paternal	□ Maternal □ Paternal
Diabetes						□ Maternal □ Paternal	□ Maternal □ Paternal
Hypertension						□ Maternal □ Paternal	□ Maternal □ Paternal
Stroke/TIA						□ Maternal □ Paternal	□ Maternal □ Paternal
Other:						□ Maternal □ Paternal	□ Maternal □ Paternal

Past Medical History: Please check all that apply								
Condition	**Yes**	**No**	**Condition**	**Yes**	**No**	**Condition**	**Yes**	**No**
Food Allergies			**Crohn's Disease**			**Hypothyroid**		
Seasonal Allergies			**Depression**			**Kidney Disease**		
Anemia			**Diabetes | Type** □ Type 1 □ Type 2 □ LADA			**Osteoporosis**		
Anxiety			**GERD**			**Seizure/Epilepsy**		
Arthritis			**Glaucoma**			**Sleep Apnea**		
Asthma			**Hepatitis | Type** □ A □ B □ C			**Stroke/TIA**		
Cancer | Type _____			**HIV/AIDS**			**Tuberculosis (TB)**		
COPD			**High Cholesterol**			**Ulcerative Colitis**		
Clotting Disorder			**Hypertension**			**Other:**		
Coronary Artery Disease or Congestive Heart Failure			**Hyperthyroid**			**Other**		

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Patient Registration Form *Your Health ~ Our Mission*

Female Reproductive History (Provide Dates If Known)

Have you been pregnant? Yes_____ No _____

Menstrual History (Provide Dates If Known)

Period started at age _____

Are you having regular periods? Yes_____ No _____

Are you having abnormal bleeding? Yes_____ No _____

Date of last pap smear: _____ Was it abnormal? Yes_____ No _____

Pregnancy (Provide Dates If Known)

How many? _____ Live Birth # _____ Miscarriage _____ Stillborn _____ Termination_____

Are you RH negative? Yes_____ No _____

Are you sexually active? Yes_____ No _____

Are you on birth control? Yes_____ No _____ If yes, what type? _____

Do you have any concerns regarding your reproductive health? _____

Have you had a tubal ligation? Yes_____ No _____

Have you had a hysterectomy? Yes_____ No _____ If yes, did they remove your ovaries? Yes_____ No _____

Do you want information regarding birth control or protection from sexually transmitted diseases? Yes_____ No _____

When was your last mammogram? _____ Was it abnormal? _____

Where did you get your mammogram performed? _____

Birth History (Provide Dates If Known)

If patient is under 1 year of age, please answer the following questions:

Birth Weight/Length: _____ lbs _____ oz _____ inches

Was your child born prematurely? Yes_____ No _____ Estimated Delivery Date: _____ Actual Delivery Date: _____

Method of Delivery _____ Vaginal _____ Caesarean If Caesarean, why? _____

Were there any complications during the birthing process? Yes_____ No _____

If yes, please explain: _____

Where there any medical problems during pregnancy? Yes_____ No _____

If yes, please explain: _____

Were there any medical problems after birth? Yes_____ No _____

If yes, please explain: _____

For Male Patient Only: Is your child circumcised? Yes_____ No _____

Were there any drugs, alcohol or cigarettes used during pregnancy? **(Provide Dates If Known)** Yes_____ No _____

PHI Designee Form

Patient Protected Health Information Designee

I understand and acknowledge that the individuals identified below will be treated by Coast Community Health Center (CCHC) as individuals involved directly in my or the registered patient's care and as such CCHC will be allowed to release the patient's personal health information to these individuals for the purpose of all aspects of patient's medical/dental treatment, written or informed consent, payment, or clinic operations.

1. Name of Designee	Date of Birth (if known)
Relation to Patient	Phone Number
2. Name of Designee	Date of Birth (if known)
Relation to Patient	Phone Number

☐ **I currently decline to provide a PHI designee contact for myself or my child.**

I understand that the above-named designee(s) have a right to request and receive a Notice of Privacy Practices from CCHC. CCHC has made the Protected Health Information Designee available to patients so that they may identify individuals that have permission to consent to treatment and receive protected health information for the patient in the absence of the patient or the patient's legal guardian or representative. By signing below, I acknowledge that I have read and understand the above statements and accept the terms.

Patient Printed Name **DOB:**_____

Patient Signature **Date:**

Patient/Parent Legal Guardian Signature: **Date:**

Coast Community Health Center
ROI Authorization

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Authorization for Release of Information (ROI)	
Patient:	**DOB:**
First Name Middle Name Last Name	

I specifically authorize the release of the following records if such records exist (Check all that apply):

☐ ALL Records	☐ Immunizations	☐ Medications	☐ Diagnostic Tests
☐ History & Physical	☐ Food/Drug Allergies	☐ Diagnoses	☐ Operative Reports
☐ Chart Notes	☐ Labs/Pathology	☐ Imaging/Radiology	☐ Consultation Reports
☐ Other _____			

Release Records FROM Facility:

Address	State	Zip	Phone	Fax Number

Release Records to: COAST COMMUNITY HEALTH CENTER

Address:	Phone:	Fax:
1010 First Street, Suite 101 Bandon, Oregon 97411	**541-347-2529**	**541-347-9196**

Dates of Service: _____ to _____

Purpose of Release (Check one below):

☐ Transferring to New Provider ☐ Continuing Care ☐ Other _____ ☐ Legal

If the records contain any information of the type(s) listed below, additional laws relating to use and disclose may apply. I understand that this information will not be disclosed unless I initial in the space next to the information:

HIV/AIDS	**Initial:**	**Mental Health**	**Initial:**
Alcohol/ Substance Use Diagnosis or Treatment	**Initial:**	**Genetic Testing**	**Initial:**

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law. Unless revoked earlier, this authorization shall remain in effect for 1 year of signing this authorization. I understand I can revoke this authorization at any time by sending written authorization to Coast Community Health Center. The cancellation will not affect any information that was already disclosed. Coast Community Health Center cannot condition treatment or eligibility of benefits on whether the authorization is signed.

_____ _____
Patient's Signature **Date**

_____ _____
Other Authorized Person (print name) **Relationship to Patient**

_____ _____
Authorized Person Signature **Date**