Dear Patient,

Welcome to Santa Barbara Neighborhood Clinics! We offer high-quality medical, dental and mental health services. Santa Barbara Neighborhood Clinics has four medical and two dental clinics in Santa Barbara, Goleta and Isla Vista. We look forward to being a partner in your health.

Our staff provides patient-centered care that looks at all your health needs. We support your choice of a primary care provider. Selecting a primary provider is important. This person will recommend steps and health goals that are right for you. They will coordinate your care with others if you need specialty services.

Nurses are available 24 hours a day to help answer your questions at 1-844-594-0343. They can assist you with medical questions, review your symptoms and help prevent unnecessary emergency room visits.

Call 1-844-594-0343, toll free, to speak with a nurse or schedule a medical appointment. Same day appointments are available. To schedule a dental appointment call Goleta Dental Clinic at 805-617-7900 or Eastside Family Dental Clinic at 805-884-1988.

In addition to our regular hours, we are open evenings and Saturday mornings to meet your needs. Clinic hours, locations and other information can be found on our website www.sbclinics.org. We offer a discount on services for patients who are low-income and uninsured.

We are here to help and happy to be your health home.

Sincerely,

Charles M. Fenzi, MD
Chief Executive Officer and Chief Medical Officer
Santa Barbara Neighborhood Clinics

SBNC
Santa Barbara Neighborhood Clinics
Your Health Home

Today's Date:_____

Patient Information

Patient Name: _____ **Date of Birth:**_____

Sex: ❑Male ❑Female **Patient SS/ITIN#:**_____**Mobile Phone:**_____

Alternate Phone: _____ **E-mail:** _____

Patient Address: _____
Street Address, City, State, Zip Code

_____

How may we contact you?

Mobile Phone	❑Yes ❑No
Alt. Phone	❑Yes ❑No
U.S. Mail	❑Yes ❑No
E-Mail	❑Yes ❑No
Patient Portal	❑Yes ❑No

Marital Status:
❑Single
❑Domestic Partner
❑Married
❑Divorced
❑Separated
❑Widowed

Work Status:
❑Not Employed
❑Full-time
❑Part-time
❑Self Employed
❑Retired
❑Student
❑Not Applicable

Primary Language:
❑English
❑Spanish
❑Other:
_____

Work Type:
❑Housekeeping, hotel and food services
❑Arts, entertainment, and recreation
❑Construction
❑Educational services
❑Federal, state, and local government
❑Finance and insurance
❑Healthcare and social assistance
❑Information Technology
❑Manufacturing
❑Professional, scientific, and technical services
❑Real estate and rental and leasing
❑Retail trade and selling of goods
❑Transportation & warehousing
❑Utility Services
❑Other
❑Not Applicable

What is the patients highest level of education completed?
❑Less than high school
❑High school diploma or equivalent
❑Some college, no degree
❑Trade School
❑Associate's degree
❑Bachelor's degree
❑Master's degree
❑Doctoral or professional degree

UDS

Present Living situation:
❑Own a Home
❑Rent (home, apartment, room)
❑Living with relatives
❑Shelter
❑Street
❑Doubling up
❑Transitional
❑Other
❑Refuse

Are you an Agricultural, Cattle, or Poultry Farm Worker?
❑Farm worker
❑Seasonal
❑Not a farm worker

Are you a veteran?
❑Yes ❑No

Race: **(Select one or more):**
❑American Indian/ Alaskan Native
❑Asian
❑Black/ African American
❑More than one race
❑Native Hawaiian
❑Pacific Islander
❑White
❑Refused
❑Other_____

Ethnicity **(select one):**
❑Hispanic/Latino
❑Not Hispanic/ Latino
❑Refused

Are you comfortable communicating in English?
❑Yes ❑No

Guarantor/Responsible Party

Is this patient the Responsible Party (over 18 years of age and/or legally responsible for self)? ❑Yes ❑No
If yes, skip to Household Income and Family Size

Responsible party name:_____ D.O.B._____

❑Parent ❑Legal Guardian ❑Healthcare Proxy ❑Other:_____ SS/ITIN#:_____

Address (if the same as patient, write "same"): _____

_____

Phone (Select preferred method):❑Home ❑Alternate ❑Mobile_____

Monthly Household Income $_____ Family Size: _____

Emergency Contact

Emergency Contact Name:_____ **Phone number:** _____

Relationship to Patient:_____

May we discuss your medical information with this person? ❑Yes ❑No

Marketing

How did you learn about this clinic?

❑Newspaper Advertising	❑Friend/Relative/SBNC Employee	❑Cottage Health/Hospital
❑Flyer/Brochure/Door hanger	❑News Article	❑School
❑Facebook/Social Media	❑Health Fair/Presentation	❑County Clinic/Behavioral Wellness
❑CenCal/Insurance	❑Community Organization	❑Other healthcare provider
❑Internet/Website	❑Radio	❑Television

Insurance(s) & Non –Provider Patient Agreement

Primary Insurance Name: _____ **ID #:**_____

Name of Insured, if not patient: _____

Secondary Insurance Name:_____ **ID #:**_____

Name of Insured, if not patient:_____

If I have been informed by a staff member that SBNC is not a participating provider of my insurance plan, SBNC has agreed to bill my insurance company as a courtesy. I understand that I am responsible for my co-payment and any unpaid portion that is not paid to SBNC by my insurance company. I will notify SBNC anytime my insurance plan changes.

Signature of Patient or Responsible Party_____ **Date:**_____

No Shows/Cancellations

After three missed appointments (not cancelled within 24 hours) in a twelve month period, you will be asked to find another healthcare provider. You will be seen for urgent care and medication refills for a 30-day period after which you will no longer be considered under the care of the Santa Barbara Neighborhood Clinics.

Three attempts shall be made to contact you. Upon the third failed attempt, a letter (Certified/Return Receipt) will be mailed to your address. A copy of the letter and receipts will be scanned into your electronic health record.

Signature of Patient or Responsible Party_____ **Date:**_____

Advanced Healthcare Directives

An Advance Health Care Directive is a way to instruct doctors, nurses and other healthcare providers about your wishes if you are unable to speak for yourself. It is a legal document that states who you wish to make decisions for you if you are unable to make them yourself due to illness or injury. It also allows you to give other instructions, like setting limits on the treatment you wish to receive if you are terminally ill or injured or donation of organs.

You do not need a lawyer to complete an Advance Health Care Directive. We can provide you with a blank form that you can complete on your own. It must be signed before a notary public or witnessed by two adults who also sign the form.

We will place a copy of your signed Advance Health Care Directive in your medical record. You should keep the original copy and it is important that your family and close friends know about the existence of the Directive and where the original is kept.

- ❑I do not desire additional information about the Advance Health Care Directive
- ❑I have already executed an Advance Health Care Directive
- ❑I would like more information about the Advance Health Care Directive

Consent for Photography

Santa Barbara Neighborhood Clinics uses stories and photographs of patients and family members in our marketing and communications publications, on our Website, in direct mail appeals, and annual reports.

By signing below, you acknowledge that you understand the above statement and authorize staff at SBNC to share photographs of you for the purposes described.

Signature of Patient or Responsible Party_____ **Date:**_____

HIE Consent

SBNC is a member of Cottage Community Health Information Exchange (CC, HIE), a secure data portal for the purposes of accessing vital health information between medical providers and the hospital for your treatment and billing. This is a disclosure that your health records may be shared, confidentially with authorized other health care providers and their business associates as members of the exchange and shall not be used or disclosed for any purposes prohibited by applicable health information privacy protection laws.

❑ No, do not share my information with the HIE/CeHC

Signature of Patient or Responsible Party_____ **Date:**_____

Acknowledgements: I have executed a copy of the SBNC Consent for Treatment and Evaluation & Acknowledgement of Receipt of Notice of Privacy Practices and I consent to the matters contained therein. By signing below I acknowledge that I have read the information on Insurances &Non-Provider Patient Agreement, No Show/Cancellation Policy, Advanced Healthcare Directives, Consent for Photography, and HIE Consent.

Signature of Patient or Responsible Party: _____**Date:**_____

Santa Barbara Neighborhood Clinics

CONFIDENTIAL PEDIATRIC MEDICAL HISTORY

Your answers will help us to provide your child with the best medical care. Some of the questions may not apply to them or seem important. Nevertheless, please answer as accurately and completely as you can. This will become a permanent part of your child's confidential medical record.

Name:_____ Birth Date:_____ Today's Date:_____

- List any medications your child has allergies to: _____
  _____
- What medications is your child taking regularly? _____
  _____
- What medical conditions does your child have? _____
  _____
- Past hospitalizations/serious illness: _____
  _____
  _____
- Please list any surgeries/operations: _____
  _____
- Does your child wear glasses or contacts? YES_____ NO_____

* *If you have your child's vaccination card, please give it to the receptionist to copy*

EARLY CHILDHOOD:

Is this child: Adopted?____ In Foster Care or Guardianship?____

Pregnancy: Did the mother have any serious illness, high fevers, rashes, toxic exposures, accidents or smoke cigarettes or drink alcohol?
YES____ NO____

Delivery: Did the mother have any problems? NO____ YES____

Newborn: Did the baby have any problems NO____ YES____

Birth Weight _____ (pounds or kilograms)

Place of Birth: City_____ Hospital _____

Onset Age: sat_____ crawled_____ walked_____ talked_____

CHILD AND FAMILY HISTORY: PLEASE CHECK THOSE THAT APPLY TO THE CHILD OR FAMILY MEMBER

Child	Family		Child	Family	
____	____	High Blood Pressure	____	____	Anemia
____	____	Heart Disease	____	____	Asthma
____	____	Cancer, Type_____	____	____	Allergies/Hay Fever
____	____	Ear Infections	____	____	Bronchitis
____	____	Migraine Headaches	____	____	Diabetes
____	____	Skin Problems	____	____	Kidney Disease
____	____	Liver Problems	____	____	Epilepsy
____	____	Digestive/Bowel Problems	____	____	Vision Problems
____	____	Genetic/Familial Condition	____	____	Thyroid Problems
____	____	Developmental Problems	____	____	Attention Difficulties
____	____	Behavioral Problems	____	____	Discipline Problems

SBNC Consent for Evaluation and Treatment
and Acknowledgement of Notice of Privacy Policies

I hereby request and consent to the performance of primary care services by a clinician of the Santa Barbara Neighborhood Clinics (SBNC). I do not expect the clinician to be able to anticipate and explain all risks and complications of the treatment to me.

I understand that, in general, the medical care received at SBNC is confidential. I understand that State law requires reporting of: positive results of certain diseases (such as gonorrhea, syphilis, hepatitis A & B, mumps, AIDS, and Lyme disease); sexual abuse, current or in the past, when the victim is under age 18; abuse of dependent adults or the elderly; or domestic violence.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Policies of SBNC, and consent to each of those policies as set forth in the current notice as posted in the reception area of the clinic.

I understand that information about my medical care may be shared among practitioners employed by SBNC. I authorize the release of any medical or other information necessary to make referral appointments and I authorize SBNC to receive reports from any referral provider. I understand that if follow-up visits to SBNC or to referral providers are needed, I assume responsibility for completing such follow-up visits.

I hereby give my permission to the employees of SBNC to use the information contained in my medical record for statistical purposes on a confidential basis.

If laboratory tests are ordered, I understand that a laboratory unaffiliated with SBNC may perform these tests. I further understand that SBNC is not responsible for reporting erroneous test results that an unaffiliated laboratory has reported to it.

I understand that I am financially responsible for all charges made at this visit, whether or not insurance or another third-party payer covers them. I authorize the release of any medical or other information necessary to process insurance or other funding source claim resulting from my visit.

I understand that I have a right to accept, refuse, or stop treatment at any time.

_____ _____

Signature of Patient if 18 years of age or older
Or Parent or Guardian

Date

_____

Printed Name of Signer

SBNC Consent for Evaluation and Treatment of a Minor

I _____, as parent or legal guardian
Name of Parent or Legal Guardian

of _____, a minor, authorize medical
Name of Patient

treatment and evaluation as deemed necessary by the medical staff of the Santa Barbara Neighborhood Clinics.

I acknowledge and understand that I am responsible for all the charges of the services rendered to this patient.

_____ _____
Signature of Parent or Guardian Date

_____
Relationship to Patient