Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

Date: _____

Patient Information

Patient Name: _____ **Date of Birth:** _____ **SS/ITIN#:** _____
MM/DD/YYYY

Birth Sex:
❑Female
❑Male

Gender Identity:
❑Choose not to disclose
❑Female
❑Male
❑Other
❑Transgender Woman/Transgender Female/Transfeminine
❑Transgender Man/Transgender Male/Transmasculine
❑Unknown

Sexual Orientation:
❑Bisexual
❑Choose not to disclose
❑Don't Know
❑Lesbian or Gay
❑Unknown
❑Straight or Heterosexual
❑Other

Preferred Pronoun:
❑Asked but unknown
❑Decline to Answer
❑He, Him, His
❑Other
❑She, Her, Hers
❑They, Them, Theirs
❑Ze, Hir

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

Mobile Phone:_____
Alternate Phone:_____
E-mail:_____

Text and Voice Reminders:
❑ Opt out
❑ SMS (Text)
❑ Voice Reminders

How may we contact you?

Alt. Phone	❑Yes ❑No
Cell Phone	❑Yes ❑No
Email	❑Yes ❑No
Home Phone	❑Yes ❑No
Patient Portal	❑Yes ❑No
U.S. Mail	❑Yes ❑No

Primary Language:
❑English
❑Spanish
❑Other:
_____

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

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

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
❑Professional, scientific, and technical services
❑Real estate and rental and leasing
❑Retail trade and selling of goods
❑Transportation & warehousing
❑Utility Services
❑Manufacturing
❑Other
❑Not Applicable

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

UDS

Present Living Situation:
❑Doubling up
❑Living with relatives
❑Not Homeless
❑Other
❑Own a Home
❑Rent home, or room
❑Shelter
❑Street
❑Transitional
❑Unknown/Unreported

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

Are you a veteran?
❑Yes ❑No

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

Ethnicity (select one):
❑Hispanic/Latino
❑Not Hispanic/Latino
❑Unreported/Refuse to Report

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

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

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, and HIE Consent.

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

Name: _____
DOB: _____

Preferred Pharmacy & Location:
_____

PATIENT MEDICAL HISTORY

(If you need assistance in filling out this form, please ask our front office staff for help)

PCP:_____ Office Phone: _____ Date of Last Medical Exam: _____

	NO	YES		NO	YES
1. Are you under medical treatment now? If yes, describe _____			5. Do you have a persistent cough or throat clearing not associated with a known illness? (Lasting more than 3 weeks)		
2. Have you ever been hospitalized for any surgical operation or serious illness? If yes, describe _____			6. Do you use tobacco? If yes, how much _____ Would you like help to quit?		
3. Are you taking any of the following?			7. Do you use or have you used recreational drugs or medicinal marijuana?		
A. Antibiotics or sulfa drugs			8. Are you pregnant or think you may be pregnant? (skip if not applicable)		
B. Anticoagulants (Blood thinners such as Coumadin, Eliquis, Xarelto, etc…)			9. Are you nursing? (skip if not applicable)		
C. Medicine for high blood pressure			**10. Are you allergic to or have you had any reactions to the following?**		
D. Digitalis or drugs for heart trouble			A. Local anesthetics (ex. Lidocaine)		
E. Nitroglycerin			B. Penicillin or other antibiotics		
F. Insulin, Metformin, Ozempic, or similar drug			C. Sulfa drugs		
G. Dilantin			D. Barbiturates		
H. Cortisone (Steroids)			E. Sedatives		
I. Oral contraceptives			F. Aspirin		
J. Tranquilizers			G. Codeine		
K. Osteoporosis drugs (Fosamax, Actonel, Prolia, Reclast, etc…)			H. Latex		
L. Chemotherapy drugs					

12. **Do you have or have you had any of the following?**	NO	YES		NO	YES
A. Cancer: If yes, describe: _____			P. Anemia or other blood disease		
B. Radiation therapy			Q. Bleeding tendency/Abnormal bleeding		
C. Leukemia			R. Aids or HIV infection		
D. Recent weight loss			S. Epilepsy/Convulsions		
E. High blood pressure			T. Fainting/Seizures		
F. Low blood pressure			U. Asthma: If yes, do you have an inhaler?		
G. Heart attack: If yes, when: _____			V. Tuberculosis		
H. Stroke: If yes, when: _____			W. Thyroid problem		
I. Prosthetic cardiac valve			X. Stomach Ulcer		
J. Infective endocarditis			Y. Arthritis		
K. Cardiac pacemaker			Z. Sexually transmitted infections		
L. Congenital heart disease			a. Hepatitis A, B, C, Jaundice/Liver disease		
M. Angina (chest pain)			b. Easily winded		
N. Diabetes: If yes, A1C: _____ Date: _____			c. Frequently tired		
O. Kidney disease			d. Anxiety or fear of Dentistry?		

13. Do you have a disability?

❑Blindness, visual impairment ❑Deafness, hearing impairment ❑Mobility impairment ❑ Developmental delay ❑Autism

Does the parent or child have difficulty completing health forms? _____

Signature of Patient or Responsible Party: _____Date: _____

If signing as parent or guardian: I hereby represent and warrant that I am legally empowered and entitled to provide above information.

Relation to patient: _____

Comments:

Signature of Dentist: _____ Date: _____

Santa Barbara Neighborhood Clinics
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SLIDING FEE SCALE ELIGIBILITY DETERMINATION APPLICATION
DO NOT complete form if your visit is covered under CenCal or Medi-Cal

Patient Name:_____Date of Birth:_____

Income: $_____Select one: ❑ Weekly ❑ Monthly ❑ Yearly

Family Size: _____*(Self, spouse and children under 18 years of age)*

Financial Verification Source and Attach Copy *(Select One):*
❑ Tax Return
❑ Unemployment
❑ Supplemental Security Income (SSI)
❑ Check Stubs
❑ Social Security Disability Insurance (SSDI)
❑ Other:_____

I certify that under penalty of perjury that I am NOT eligible or currently covered by CenCal or Medi-Cal Initial:_____

I understand payment is due and collected at the time of service. Initial:_____

I understand medications may be at an additional charge. Initial:_____

I understand laboratory services may be at an additional charge. Initial:_____

I understand procedures may be at an additional charge. Initial:_____

I understand specialty appointments may be at an additional charge. Initial:_____

Patient/Parent/Guardian Signature:_____Date:_____

Revised: 3/27/2017

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

MRN:_____

Name: _____

Consent for Evaluation and Treatment

Santa Barbara Neighborhood Clinics (SBNC) is dedicated to providing primary medical, dental, behavioral health, and substance use disorder services. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. SBNC patients may be referred to providers from other health care specialties within the SBNC treatment team; members of the treatment team will share clinical information with each other as is clinically necessary.

Patients will be seen by appointment only, except in emergencies. All SBNC Clinics maintain same day appointments for urgencies. Patients are requested to cancel at least 24 hours in advance if the patient cannot keep their appointment.

Information about the patient will NOT be given to anyone outside SBNC, including family and friends, unless the patient (parent or legal guardian, of a minor) gives written permission. Patient may consent to release of his/her information if Patient is age 12 or older for behavioral health and family planning care, 18 or older for primary or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) There is evidence of child abuse; or 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly. Please refer to SBNC's HIPAA Privacy Policy.

There are fees for all services, and Patient is required to pay on the day of service. Health insurance policies may cover all or a portion of the fees and staff will help Patient in understanding their financial responsibility. Patient shall tell SBNC staff about changes in financial status including insurance.

The professional staff of SBNC will depend on statements made by Patient, Patient's medical history, and other information to evaluate their condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Health professions are not exact sciences and no guarantees are made concerning the course or effect of treatment proposed by the provider, nor outcomes of treatment. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including imaging, (x-rays, photographs, and scans), laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patient accepts the risks of medication and other treatment.

I understand, that if I am 12 years of age or older, I may consent for Mental Health, substance use disorder and/or Reproductive Health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or my child(ren) as set forth above, including any studies or procedures that SBNC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

_____ _____

Patient's and/or Guardian's Signature Date

_____

Print Name

_____ _____

Witness Date

Santa Barbara Neighborhood Clinics
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AUTHORIZATION AND CONSENT FOR PHOTOGRAPHY

AUTORIZACIÓN Y CONSENTIMIENTO PARA USO DE FOTOGRAFÍAS

Patient Name: _____

DOB: _____

Gender: _____

The undersigned herby authorizes Santa Barbara Neighborhood Clinics to photograph . The undersigned agrees that the above named organization may not use and permit other persons to use the negative print prepared from such photograph for any purpose other than the dental record.

La persona que aquí firma da su autorización por este medio a Las Clínicas de Santa Barbara Neighborhood, para tomar fotos . La persona que aquí firma está de acuerdo en que la organización arriba mencionada, no pueda usar y permitir que otras personas utilicen las impresiones negativas pareparadas por este fotógrafo para otro fin más que el expediente dental.

- ❑ I, decline to have my photograph taken.
- ❑ *Yo, me niego a ser fotografiado.*

Signature: _____ Date: _____