

Patient Information	Patient Name: _____ Date of Birth: _____ SS/ITIN#: _____ <div style="text-align: center;">MM/DD/YYYY</div>					
	Birth Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity: <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Transgender Woman/Transgender Female/Transfeminine <input type="checkbox"/> Transgender Man/Transgender Male/Transmasculine <input type="checkbox"/> Unknown	Sexual Orientation: <input type="checkbox"/> Bisexual <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Don't Know <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Unknown <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Other	Preferred Pronoun: <input type="checkbox"/> Asked but unknown <input type="checkbox"/> Decline to Answer <input type="checkbox"/> He, Him, His <input type="checkbox"/> Other <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Ze, Hir		
	Address: _____ <div style="text-align: center;">Street Address, City, State, Zip Code</div>		Mobile Phone: _____ Alternate Phone: _____ E-mail: _____			
	Text and Voice Reminders: <input type="checkbox"/> Opt out <input type="checkbox"/> SMS (Text) <input type="checkbox"/> Voice Reminders					
	How may we contact you? Alt. Phone <input type="checkbox"/> Yes <input type="checkbox"/> No Cell Phone <input type="checkbox"/> Yes <input type="checkbox"/> No Email <input type="checkbox"/> Yes <input type="checkbox"/> No Home Phone <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Portal <input type="checkbox"/> Yes <input type="checkbox"/> No U.S. Mail <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Work Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Not Applicable <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-time <input type="checkbox"/> Refused <input type="checkbox"/> Retired		
		<input type="checkbox"/> Self Employed <input type="checkbox"/> Student <input type="checkbox"/> Unknown				
Work Type: <input type="checkbox"/> Housekeeping, hotel and food services <input type="checkbox"/> Arts, entertainment, and recreation <input type="checkbox"/> Construction <input type="checkbox"/> Educational services <input type="checkbox"/> Federal, state, and local government <input type="checkbox"/> Finance and insurance <input type="checkbox"/> Healthcare and social assistance <input type="checkbox"/> Information Technology <input type="checkbox"/> Professional, scientific, and technical services <input type="checkbox"/> Real estate and rental and leasing <input type="checkbox"/> Retail trade and selling of goods				<input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Utility Services <input type="checkbox"/> Manufacturing <input type="checkbox"/> Other <input type="checkbox"/> Not Applicable		
				What is the patient's highest level of education completed? <input type="checkbox"/> Less than high school <input type="checkbox"/> High school diploma or equivalent <input type="checkbox"/> Trade School <input type="checkbox"/> Some college, no degree <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Doctoral or professional degree <input type="checkbox"/> Unreported/Refuse To Report		
UDS	Present Living Situation: <input type="checkbox"/> Doubling up <input type="checkbox"/> Living with relatives <input type="checkbox"/> Not Homeless <input type="checkbox"/> Other <input type="checkbox"/> Own a Home <input type="checkbox"/> Rent home, or room <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transitional <input type="checkbox"/> Unknown/Unreported		Are you an Agricultural, Cattle, or Poultry Farm Worker? <input type="checkbox"/> Farmworker <input type="checkbox"/> Not a Farmworker <input type="checkbox"/> Seasonal		Race: (Select one or more): <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> More than one race/Other <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Unreported/Refused to Report Race <input type="checkbox"/> White	
			Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Ethnicity (select one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported/Refuse to Report Are you comfortable communicating in English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Guarantor/Responsible Party	Is this patient the Responsible Party (over 18 years of age and/or legally responsible for self)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, skip to Household Income and Family Size					
	Responsible party name: _____ D.O.B. _____					
	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Healthcare Proxy <input type="checkbox"/> Other: _____ SS/ITIN#: _____					
	Address (if the same as patient, write "same"): _____ _____ _____					
Phone (Select preferred method): <input type="checkbox"/> Home <input type="checkbox"/> Alternate <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marketing	How did you learn about this clinic? <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/>Newspaper Advertising <input type="checkbox"/>School <input type="checkbox"/>Television <input type="checkbox"/>Radio <input type="checkbox"/>CenCal/Insurance </div> <div style="width: 30%;"> <input type="checkbox"/>Internet/Website <input type="checkbox"/>Cottage Health/Hospital <input type="checkbox"/>News Article <input type="checkbox"/>Health Fair/Presentation <input type="checkbox"/>Community Organization </div> <div style="width: 30%;"> <input type="checkbox"/>Friend/Relative/SBNC Employee <input type="checkbox"/>Flyer/Brochure/Door Hanger <input type="checkbox"/>County Clinic/Behavioral Wellness <input type="checkbox"/>Other Healthcare Provider <input type="checkbox"/>Facebook/Social Media </div> </div>		
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. <input type="checkbox"/> I do not desire additional information about the Advance Health Care Directive <input type="checkbox"/> I have already executed an Advance Health Care Directive <input type="checkbox"/> 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. <input type="checkbox"/> 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:** _____

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: _____ Date of Birth: _____ Today's Date: _____

- List any medications your child has allergies to: _____
- What medication is you 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 CHILHOOD

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

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? Yes _____ No _____

Newborn: Did the baby have any problems Yes _____ No _____

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

Does your child have a disability?

☐ Blindness, visual impairment

☐ Deafness, hearing impairment

☐ Mobility impairment

Does the parent or child have difficulty completing health forms?

Comments:

Provider Signature: _____ **Date** _____

Signature of Patient or Responsible Party _____



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

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



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: _____