Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

Patient Demographic Form

Date: _____

Patient Information

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

Birth Sex:
❑Female
❑Male

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

Sexual Orientation:
❑Bisexual
❑Choose not to disclose
❑Don't Know
❑Lesbian, gay, or homosexual
❑Something else
❑Straight or Heterosexual

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:** _____

Santa Barbara Neighborhood Clinics

CONFIDENTIAL ADULT MEDICAL & DENTAL HISTORY

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

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

Care Coordination

Other Healthcare Providers' information: ❑None

Primary Care Provider: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Preferred Pharmacy Location:

_____

_____

Social

Do you use Tobacco? ❑YES ❑NO ❑Former, If yes: # per day_____ # of years_____ Quit Date_____

Would you like help quitting? ❑YES ❑NO

Do you drink alcohol? ❑Daily ❑1-3/week ❑1-3/month ❑Rarely ❑Never

Do you or have you used recreational drugs or medicinal marijuana? ❑YES ❑NO If so, which/frequency? _____

Medications & Allergies

Are you taking any medication(s) including non-prescription medicine (i.e. herbal supplements)? ❑None

_____

_____

_____

List any medications you are allergic to: ❑None

❑Penicillin or Other Antibiotics

❑Sulfa Drugs ❑Barbiturates ❑Sedatives ❑Aspirin

❑Codeine ❑Latex ❑Other:

_____

_____

Personal & Family History

Please check those that apply to you or a family member.

Me	Family		Me	Family	
❑	❑	High Blood Pressure	❑	❑	Thyroid Problems
❑	❑	Heart Disease	❑	❑	Diabetes
❑	❑	High Cholesterol	❑	❑	Digestive/Bowel Problems
❑	❑	Stroke	❑	❑	Heart Attack
If yes, when_____			If yes, when_____		
❑	❑	Ulcer Disease/ Acid Reflux	❑	❑	Liver Disease/Hepatitis
❑	❑	Tuberculosis	❑	❑	Sexually Transmitted Diseases
❑	❑	Migraine Headaches	❑	❑	Cancer _____
❑	❑	Vision problems	❑	❑	Depression/Mental Illness
❑	❑	Allergies/Hay Fever	❑	❑	AIDS or HIV Infection
❑	❑	Kidney Disease	❑	❑	Seizures/Epilepsy
❑	❑	Hernia	❑	❑	Arthritis
❑	❑	Anemia/Bleeding Disorders	❑	❑	Low Blood Pressure
❑	❑	Radiation/Chemotherapy	❑	❑	Chronic Disease, specify below:
❑	❑	Pace Maker			_____
❑	❑	Osteoporosis			

Immunizations:

Year of most recent Tetanus

Booster_____

Please provide us with your vaccine record, if available

Please list any surgeries/operations: ❑None

_____

Do you have any dental concerns? ❑Yes ❑No

Do you have any artificial joints or implants? ❑Yes ❑No

Do you bleed excessively? ❑Yes ❑No

Have you ever taken medications for osteoporosis? ❑Yes ❑No

Do your gums bleed? ❑Yes ❑No

Other History

Do you have a disability?

❑ Blindness, visual impairment

❑ Deafness, hearing impairment

❑ Mobility impairment

Do you have difficulty completing health forms?

_____

Are you pregnant or think you may be pregnant? ❑Yes ❑No

Are you nursing? ❑Yes ❑No

Are you taking birth control? ❑Yes ❑No

If yes, which_____

Etc.

Comments:

Provider Signature:_____ **Date**_____

Signature of Patient or Responsible Party_____

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

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
Quality Affordable Healthcare

Patient Quality Questionnaire

Name:	Date of Birth:	Today's Date:

A	**Have you ever been vaccinated? ☐ Yes ☐ No ☐ Don't Know | *If answered No, skip to next section.***
	Have you had a tetanus vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
	Have you had a pneumonia vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
	Have you had a shingles vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
	Have you had an HPV vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
	Have you had a Hepatitis A vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
	Have you had a Hepatitis B vaccine? ☐ Yes ☐ No ☐ Don't Know | When: _____Where:_____
B	**Do you use tobacco? ☐ Yes ☐ No | *If answered No, skip to next section.***
	Tobacco Type: ☐ Cigarette ☐ Cigarillo ☐ Cigar ☐ Pipe ☐ Chewing ☐ Smokeless ☐ Snuff ☐ E-cigarette/Vape
	How many per day_____ for how many years_____
	Have you tried to quit? ☐ Yes ☐ No | Do you want to quit now? ☐ Yes ☐ No ☐ Don't Know
C	**Do you have high blood pressure? ☐ Yes ☐ No ☐ Don't Know | *If answered No, skip to next section.***
	Are you or have you been on medication for high blood pressure? ☐ Yes ☐ No ☐ Don't Know
	If yes, which ones? _____
	Have you had blood tests in the last year? ☐ Yes ☐ No ☐ Don't Know
	If yes, where? _____
D	**Do you have a diagnosis of depression? ☐ Yes ☐ No ☐ Don't Know | *If answered No, skip to next section.***
	Are you or have you been on medication for depression? ☐ Yes ☐ No ☐ Don't Know
	If yes, which ones? _____
	Who is your depression provider? _____ Date last seen: _____
E	**Do you have diabetes? ☐ Yes ☐ No ☐ Don't Know | *If answered No, skip to next section.***
	Are you or have you been on medication for diabetes? ☐ Yes ☐ No ☐ Don't Know
	If yes, which ones? _____
	When was your last Hemoglobin A1C? _____Result? _____Where? _____
	Date of last blood test: When? _____Where? _____☐ Don't Know
	Date of last Diabetic eye exam: When? _____Where? _____☐ Don't Know
	Date of last foot exam: When? _____Where? _____☐ Don't Know

F	**Do you have or have you ever had asthma? □ Yes □ No □ Don't Know | *If answered No, skip to next section.***
	Are you or have you been on medication for asthma? □ Yes □ No □ Don't Know If yes, which ones? _____ Do you use Albuterol/Proair/Ventolin/Proventil/Xopenex? □ Yes □ No □ Don't Know | If yes, circle one How often in an average week? _____
G	**Have you ever had a heart attack or do you have known coronary artery disease? □ Yes □ No □ Don't Know**
	Do you take a medication for high cholesterol? □ Yes □ No □ Don't Know Which one(s)? _____
H	**Do you have Ischemic Coronary Vascular Disease (Have you ever had a stroke or a heart attack)?**
	When_____ Do you take aspirin /Eliquis/Brilinta/Xarelto? □ Yes □ No □ Don't Know
I	***If applicable to you***
	Have you had a pap smear? □ Yes □ No □ Don't Know | When: _____Where:_____ Have you had a hysterectomy? □ Yes □ No □ Don't Know | When: _____Where:_____ Was it due to cancer or an abnormal pap smear? □ Yes □ No □ Don't Know Have you had a mammogram in the past? □ Yes □ No □ Don't Know | When: _____Where:_____
J	**If you are over 50 years old, have you ever had a screening test for colon cancer? □ Yes □ No □ Don't Know**
	Screening type: □ Stool-based Test □ Colonoscopy □ Sigmoidoscopy □ Don't know Date Performed:_____ Result:_____

Please sign the attached medical records release form, so we may obtain documentation of any yes answers, in order to keep a more complete medical record for you.

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

Drug Abuse Screening Test (DAST)

Name: _____ Date of Birth: _____ Date: _____

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question. If the answers for both questions number 1 and 2 are "NO", please do no continue with the rest of the screening test. Once completed, return the screening test to a SBNC staff member.

	NO	YES
1. Have you used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs and/or alcohol?		
STOP IF ANSWERED "NO" TO THE FIRST TWO QUESTIONS		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs and/or alcohol (other than those required for medical reasons)		
5. Are you always able to stop using drugs and/or alcohol when you want to?		
6. Have you had "blackouts" or "flashbacks" as a result of drug use and/or alcohol use?		
7. Do you ever feel bad or guilty about your drug and/or alcohol use?		
8. Does your spouse (or parents) ever complain about your involvement with drugs and/or alcohol?		
9. Has drug and/or alcohol abuse created problems between you and your spouse or your parents?		
10. Have you lost friends because of your use of drugs and/or alcohol?		
11. Have you neglected your family because of your use of drugs and/or alcohol?		
12. Have you been in trouble at work because of your use of drugs and/or alcohol?		
13. Have you lost a job because of drug and/or alcohol abuse?		
14. Have you gotten into fights when under the influence of drugs and/or alcohol?		
15. Have you engaged in illegal activities when under the influence of drugs and/or alcohol?		
16. Have you been arrested for possession of illegal drugs?		
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs and/or alcohol?		
18. Have you had medical problems as a result of your drug and/or alcohol use (e.g. memory loss, hepatitis, convulsion bleeding, etc.)?		
19. Have you gone to anyone for help for a drug and/or alcohol problem?		
20. Have you been involved in a treatment program especially related to drug and/or alcohol use?		

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

SBNC Patient Health Questionnaire (PHQ-2 PHQ-9)

Name:_____ **MRN**:_____ **Date**:_____

During the last two weeks, have you been bothered by the following problems?

	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things?	**0**	**1**	**2**	**3**
Feeling down, depressed, irritable or hopeless?	**0**	**1**	**2**	**3**

If you answered "Yes" to either question above, please answer all questions below:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answers)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself or feeling like you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself in someway	**0**	**1**	**2**	**3**

Add Columns:	+	+	

Total: _____

If you checked off *any* problems, *how* difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

Referred to:

❒ SBNC ❒ Primary Care ❒ Support Group **Reviewed:**_____

❒ Psychiatrist ❒ LCSW ❒ Community Referral:

❒ Declined ❒ Other _____ **Date**:_____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T____* = ____ + ____ + ____)

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

Tuberculosis Skin Test Screening Questionnaire

Patient Name:_____MRN_____DOB_____DOS_____

Please answer the following questions:	Yes	No
Have you been told you are HIV positive?		
Have you been told that your Chest X-ray was positive for Tuberculosis?		
Have you had close contact with someone with active TB in the last year?		
Have you had a transplanted organ?		
Do you have any medical condition that suppresses the immune system? (For example – are you on chemotherapy or radiation treatment for cancer, are you taking chronic prednisone or other immunosuppressive therapy, HIV, or AIDS, or substance use disorder?)		
Do you have any other chronic medical conditions?		
Were you born in an area where TB is common? (Areas other than North America or Western Europe)		
Have you traveled outside the USA since your last TB test? (Particularly, have you lived or traveled extensively in Africa, Asia, Central America, Mexico, or South America?)		
Do you now, or have you ever used IV drugs?		
Do you live or work in a homeless shelter, jail/prison, nursing home, or drug/alcohol detox facility?		
Do you work in a medical facility?		
In the Past Year, Have You Had Any of the Following?	Yes	No
Frequent, unexplained fevers		
Drenching night sweats, frequently		
Persistent unexplained cough		
Coughing up of blood or blood tinged sputum/mucus		
Have you lost weight in the last year without trying?		
Unexplained difficulty breathing		
Have you ever had the BCG vaccine?		
Have you ever had a chest X-ray as a test for TB? Was it positive or negative? When?	+	-
	Yes	No
Have you ever tested positive for TB? If yes, when?		

Santa Barbara Neighborhood Clinics
Quality Affordable Healthcare

SBNC Patient Rights and Responsibilities

As an SBNC patient, you have the right to:

1. Courteous and considerate treatment and to be treated with dignity and respect by all SBNC clinicians and staff.
2. Have the privacy and confidentiality regarding your medical records to be protected.
3. Receive reasonable information regarding the qualifications of the provider of care, risks of a given treatment, and the length of disability — prior to giving consent for any procedure.
4. A reasonable response to a request for services, including evaluations and referrals.
5. Be fully informed of the Santa Barbara Neighborhood Clinics' grievance procedure and how to use it without fear of prejudice treatment from your health care provider.
6. Voice complaints and receive a timely response.
7. Receive a second opinion when such an opinion is deemed medically appropriate by the assigned.
8. Receive, upon request, the names, specialties, and titles of the professionals responsible for their care.

As an SBNC patient, you are responsible to:

1. Cooperate with those providing health care services. However, you have the right to refuse medical treatment.
2. Treat all clinic staff and providers with courtesy and respect.
3. Contact your clinic regarding any questions or concerns about your health or services, or when seeking care (except in an emergency).
4. Provide the professional staff with all the information they need to give you the best care possible.
5. Follow instructions and guidelines given by those providing health care services.
6. Keep all appointments and arrive on time. If you are unable to keep an appointment, it is to be canceled 24 hours in advance.
7. Follow the recommendations for preventive care, yearly check-ups, and a healthy lifestyle.
8. Not consume alcohol or substances while on the premises.
9. Not come to the clinic while under the influence of alcohol or drugs as this may impair your ability to fully engage in your treatment.

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

Signature: _____ **Date:** _____