COMMUNITY HEALTH REPRESENTATIVE PROGRAM (CHR)

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____

Ethnicity/Race: _____ Weight: _____ Height: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse Name: _____ Spouse Phone: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ E-Mail: _____

Home Phone: _____ Mobile Phone: _____

TREATING PHYSICIANS

Primary Care Physician: _____ Phone: _____

List all other active treating physicians:

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

RECENT SURGICAL HISTORY

List any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Description Doctor Location Year

HEALTH CONCERNS

What's your primary health concern? _____

Approximately when did this issue begin? _____

Does the issue cause you pain? ☐ Yes ☐ No

· If so, where? _____

How has the pain changed since it began? ☐ Increased ☐ Decreased ☐ Unchanged

How quickly did you current pain begin? ☐ Gradually ☐ Suddenly

How often does your pain occur? ☐ Constantly ☐ Occasionally ☐ Rarely

When is your pain at its worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

SOCIAL HISTORY

Do you currently consume alcohol? ☐ Yes ☐ No

· How many drinks per week? _____

Do you currently smoke? ☐ Yes ☐ No

· What do you smoke? ☐ Tobacco ☐ Marijuana ☐ Other: _____

· How many cigarettes do you smoke per day? _____

Do you currently use any other drugs? ☐ Yes ☐ No

· What other drugs do you take? _____

· How often? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

How frequently do you exercise? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely

Are you on a special diet? ☐ Yes ☐ No

· What diet? _____

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) Accurate Information. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) Patient Rights and Responsibilities. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I

understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) Release of Medical Information. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

d) Consent for Treatment. I grant the CHR Program, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) Consent to Communication. I consent to receiving communications from the facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.

Patient Signature: _____ Date: _____