SAN DIEGO FAMILY CARE
A California Non-Profit Corporation

ENSKRIPSYON PASYAN AK FÒM KONSANTMAN

ENFÒMASYON PASYAN

Siyati/ non fanmi w':	**Prenon:**	**Dezyem non:**	**Eta sivil:** ❑Selibatè ❑marye ❑divòse ❑separe ❑vèv
Non nesans oswa non anvan:			**Idantite sèks:** ❑ G ❑ F ❑ chwazi pa divilgasyon
Sekirite Sosyal #:	**Dat fèt:** / /		**Oryantasyon seksyèl:** ❑ Dwat ❑ Omoseksyel ❑ biseksyèl ❑ Yon lòt bagay ❑ pa konnen ❑ chwazi pa divilgasyon

Adrès lari:	**Apt. #:**	**Vil:**	**eta:**	**Kòd postal:**

Ras: (chwazi tout sa ki aplike) ❑ Blan ❑ Nwa / Afriken Ameriken Endyen ❑ / Alaska Natif Natal ❑ Azyatik ❑ zile ❑ Natif natal Azyatik ❑ Plis pase yon ras ❑ Refize rapòte	**Etnisite:** (chwazi yon sèl) ❑ Panyòl ❑ ki pa Panyòl ❑ Refize rapòte	**Bezwen yon Tradiktè oswa Entèprèt?** ❑ Wi ❑ Non **Si Wi, ki lang pasyan an pi pito?**

Primè / Telefòn Kay la#: ( )	**Selile #:** ( )	**Adrès imèl:**

Si w se paran yon timoun ant laj 12 ak 17 lane, y ap aksè a dosye medikal pitit ou a.	**Selile #(pasyan 12-17 ane):**	**Adrès imèl (pasyan 12-17 ane):**

Lojman: (Si moun ki sanzabri, tcheke aplikab) ❑ Nan abri sanzabri ❑ nan lojman tranzisyonèl ❑ lòt ❑ k ap viv nan lari a ❑ Double moute ❑ enkoni	**Èske ou se yon Veteran:** ❑ Wi ❑ Non	**Lojman Piblik:** Èske ou se yon rezidan Lojman Piblik? ❑ Wi ❑ Non	**Èske ou se yon travayè agrikòl? ❑ Wi ❑ Non** **Si repons lan se wi, chwazi youn:** ❑ Travayè sezon ❑ migran

ENFÒMASYON SOU REVNI AK REVNI

Moun ki responsab pou bòdwo: (Non, Dat nesans ak enfòmasyon sou kontak)

Gwosè Fanmi:	**Revni chak mwa:**	**Estati travay :** ❑ Anplwaye ❑ pa travay
Edikasyon: ❑ Pa yon elèv ❑ a tan pasyèl pou elèv a tanzantan ❑		**Sous revni:**

ENFÒMASYON SOU ASIRANS SANTE
Tanpri prezante kat Asirans (yo) nan Resepsyonis

Èske ou gen Asirans Sante? ❑ Wi ❑ Non **Èske ou gen Asirans dantè?** ❑ Wi ❑ Non	**Èske ou gen ase lajan Pak Fanmi (FPACT)?** ❑ Wi ❑ Non **Èske ou gen asirans medikal nan travay oswa Travay mari oswa madanm, Inyon oswa asirans prive w' achte?** ❑ Wi ❑ Non

NAN KA IJANS

Kontak Ijans : Fe-apel:	**Relasyon ak maladi:**	**Kay Telefòn #:** ( )	**Selil #:** ( )

Mwen mande epi bay pèmisyon mwen nan Swen San Diego Ak doktè ki asiyen li yo - pèsonèl oksilyè yo rann tretman sa yo jan sa nesesè. Tretman sa a se enkli tès laboratwa, radyoloji ak mezi soutni lavi, si sa nesesè. Mwen konprann pèsonèl oksilyè gen ladan Pratik Enfimyè, Enfimyè, ak Asistan medikal. Li se plis konprann ke si mwen refize nenpòt tretman sijere San Diego Swen Fanmi, mwen otomatikman lage yo soti nan responsablite pou domaj ki ka rive paske nan refize mwen. Mwen reyalize ke refi mwen yo pral dokimante ak temwen pa mwens pase de moun, ki gen ladan doktè a sipèvize an chaj. **Inisyal _____**

Direktiv avanse: Mwen te resevwa enfòmasyon sou direktiv avanse e mwen konprann ke mwen gen dwa pou fòmile direktiv avanse ki ta dwe depoze nan dosye medikal mwen an. Mwen konprann mwen ka chanje enstriksyon mwen an si mwen ta dezi alavni. **Inisyal _____**

Plasman Asirans nan Benefis: Enfòmasyon ki anwo yo konplè epi kòrèk. Mwen otorize lage enfòmasyon ki nesesè pou depoze yon reklamasyon ak konpayi asirans mwen an epi mwen bay benefis otreman peyab pou mwen, nan klinik la ki endike sou reklamasyon an. Mwen konprann mwen responsab finansyèman pou chaj ki pa kouvri pa asirans mwen oswa pa pwogram ke mwen detèmine pou mwen pa elijib pou. **Inisyal _____**

Sèvi ak, Divilgasyon foto: Mwen rekonèt ke San Diego Swen Fanmi ak anplwaye li yo gen pèmisyon mwen pou foto tèt mwen oswa manm fanmi mwen pou ede nan idantifye dosye medikal ki asosye nan Sistèm Dosye Medikal Elektwonik la, ki konsistan avèk Kalifòni ak lwa Federal konsènan vi prive endividyèlman idantifye. Foto sa a pa pral itilize pou nenpòt ki lòt rezon pase idantifikasyon pasyan pou swen nan klinik. Mwen konprann ke San Diego Swen Fanmi ka pa lage foto mwen nan nenpòt lòt founisè medikal / founisè medikal san pèmisyon mwen. **Mwen otorize** itilizasyon foto ❑Wi ❑ Non Premye___

Kominikasyon: Mwen otorize San Diego Family Care ak anplwaye li yo kontakte m 'atravè mesaj tèks oswa kite yon mesaj vwa pou mwen.

Mesaj tèks ❑Wi ❑ Non **Mesaj Vocal**: ❑Wi ❑ Non **Mesaj elektwonik**: ❑Wi ❑ Non **inisyal**___

_____ _____

Pasyan / Paran oswa siyati gadyen *Dat*

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PATIENT REGISTRATION AND CONSENT FORM

PATIENT INFORMATION

Last Name: | **First Name:** | **Middle Name:** | **Marital Status:** ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Birth Name or Previous Name: | **Gender Identity:** ❑ M ❑ F ❑ Chose not to disclose

Social Security #: | **Date of Birth:** / / | **Sexual Orientation:** ❑ Straight ❑ Lesbian or Gay ❑ Bisexual ❑ Something else ❑ Don't know ❑ Chose not to disclose

Street Address: | **Apt. #:** | **City:** | **State:** | **ZIP Code:**

Race: (select all that apply)
❑ White ❑ Black / African American ❑ American Indian / Alaska Native
❑ Asian ❑ Pacific Islander ❑ Native Hawaiian
❑ More than one race ❑ Refuse to Report

Ethnicity: (select one)
❑ Hispanic
❑ Non-Hispanic
❑ Refuse to Report

Need a Translator or Interpreter?
❑ Yes ❑ No
If Yes, what is patient's preferred language?

Primary/ Home Phone #: ( ) | **Cell #:** ( ) | **Email address:**

If you are the parent of a child between the ages 12 and 17, You will be granted partial access to your child's medical record. | **Cell #(patients 12-17 years):** | **Email address(patients 12-17 years):**

Housing: (If Homeless, check applicable)
❑ In homeless shelter ❑ In transitional housing ❑ Other
❑ Living on the Street ❑ Doubling Up ❑ Unknown

Are you a Veteran:
❑ Yes
❑ No

Public Housing:
Are you a Public Housing Resident? ❑ Yes ❑ No

Are you an Agricultural Worker?
❑ Yes ❑ No
If yes, select one:
❑ Migrant ❑ Seasonal Worker

FAMILY AND INCOME INFORMATION

Person responsible for bill: (Name, Date of Birth and Contact Information)

Family Size: | **Monthly Income:** | **Employment Status :** ❑ Employed ❑ Not Employed

Education: ❑ Not a Student ❑ Full-Time Student ❑ Part-Time Student | **Source of Income:**

HEALTH INSURANCE INFORMATION
Please present Insurance Card(s) to Receptionist

Do you have Health Insurance? ❑ Yes ❑ No
Do you have Dental Coverage? ❑ Yes ❑ No

Do you have Family Pact coverage (FPACT)? ❑ Yes ❑ No
Do you have medical coverage through work or Spouse's work, Union or privately purchased insurance? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Emergency Contact : Name: | **Relationship to patient:** | **Home Phone #:** ( ) | **Cell #:** ( )

I request and give my permission to San Diego Family Care and its assigned physicians & auxiliary personnel to render such treatment necessary as determined by my condition. Such treatment is to include laboratory tests, radiology and life-sustaining measures, if necessary. I understand auxiliary personnel include Nurse Practitioner, Nurse, & Medical Assistant. It is further understood that if I refuse any treatment suggested San Diego Family Care, I automatically release them from responsibility for damages which may occur because of my refusal. I realize my refusal will be documented and witnessed by no less than two persons, including the supervising physician in charge. **Initials** _____

Advance Directive: I have received information about advance directive and I understand that I have the right to formulate advance directives that would be filed in my medical file. I understand that I can change my instruction if I desire in the future. **Initials** _____

Insurance Assignment of Benefits: The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me, to the clinic indicated on the claim. I understand that I am financially responsible for charges not covered by my insurance or by programs that I am determined to be ineligible for. **Initials** _____

Use, Disclosure of Photographs: I hereby acknowledge that San Diego Family Care and its staff have my permission to photograph myself or my family member to assist in identifying the associated medical record in the Electronic Medical Record System, consistent with California and Federal law concerning the privacy of individually identifiable health. This photograph will not be used for any other purpose than identification of patient for clinical care. I understand that San Diego Family Care may not release my photograph to any other requestor/medical provider without my permission.

I authorize the use of photograph ❑Yes ❑ No **Initials**_____

Communications: I authorize San Diego Family Care and its staff to contact me via text message or to leave a voice message for me.

Text Message ❑Yes ❑ No **Voice Message**: ❑Yes ❑ No **Electronic Message**: ❑Yes ❑ No **Initials**_____

_____ _____

Patient / Parent or Guardian Signature *Date*