Gulf Coast Health Center, Inc.
(877) 983-1161

Patient Number	
Chart Number	

PATIENT INFORMATION / BACKGROUND/INFORMACION DEL PACIENTE

Name (Nombre):	Address (Direccion):	Telephone (Telefono):
Sex (sexo): ___ Male ____ Female DOB _____ SSN(SEGURO)_____	City/State/Zip (Ciudad/Estado/Codigo):	Occupation (oficio):
Primary Language (Cual es su lenguaje): ___ English ____ Spanish ____ Other	Highest Level of Education (educasion): ____ Elementary(Primaria) ____ High School / GED (secundaria) ____ College (colegio)	Number of Children: (Cuantos ninos tiene) Ages of Children: (Edades)
Marital Status (estatus matrimonial): ___ Single (Soltero) ___ Married (Casado) ___ Divorced (Divorciado)___ Widow (Viudo) ___ Separated (Separado) Are you a US Veteran (es usted veterano)? ___ Yes(si) No___	Race (raza): Are you Hispanic or latino? ___ yes ___ no ___ Asian ___ Native Hawaiian ___ Other Pacific Islander ___ Black / African American ___ American Indian ___ White ___ More Than One Race ___ I chose not to report	What Type of Medical Insurance do you have? (Que tipo de aseguranza tiene?) ____ Medicaid ____ Medicare ____ Private Insurance (aseguranza privada) ____ Self – Pay (Pago en efectivo)

MEDICAL HISTORY/HISTORIA MEDICA

Please answer YES or NO to the questions below:		Over the past two weeks, have you been bothered with the following? En las ultimas dos semanas, a tenido lo siguiente?
Do you smoke or use tobacco products? Fuma o usa productos de tobacco?		Little interest or pleasure in doing things? Poquito interes o placer en hacer cosas? ____ Yes (si) No___
Are you allergic to any medications? Tiene usted alergia a medicamentos?		
Do you drink alcohol? Consume alcol?		
Do you use drugs? Consume drogas?		Feeling down, depressed, or hopeless? Se siente triste, depressibo, sin salida?
Any other allergies? Alguna otra alergia?		____ Yes(si) No___
If you answered yes to any question above, please give details below: Si contesto Si alguna pregunta de arriba porfavor de su esplicasion abajo.		

Please list any major illnesses: Porfavor indique si tiene alguna enfermedad:	
Please list your current medications: Nobre de su medicina actual:	
Please list all major operations or hospitalizations: Porfavor indique si a tenido operaciones o a estado en el hospital:	

Please list relation and age of any family members who have suffered from the following: Porfavor nobre la relacion y edad de algun familiar que tenga lo siguiente:	
Diabetes	
Hypertension (alta precion)	
Cancer	
Heart Attack (ataque del Corazon)	
Stroke (embolio)	

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I give permission for Gulf Coast Health Center, Inc. staff to leave information with the following authorized people:
Yo le doy permiso a Gulf Coast Health Center de dejar mi informacion medica con la siguente persona:

Name/Relationship to patient (Nombre/Relaccion)	Name/Relationship to patient (Nombre/Relaccion)
Phone# Numero de telefono	Phone# numero de telefono

CONSENT FOR TREATMENT AND AUTHORIZATION TO FURNISH AND/OR OBTAIN MEDICAL RECORDS

CONSENTIMIENTO DE ATTENCION MEDICA Y AUTORISACION PARA OBTENER/DIBULGAR INFORMACION MEDICA

With the procedures and hazards having been fully explained, the undersigned consents to any x-ray, anesthesia, medical, surgical, or dental treatment rendered the patient by physicians, designated clinic personnel including Registered Nurses, Licensed Vocational Nurses, Nurses' Aides, Medical Assistant, Nurse Practitioners, Physician Assistants, Pharmacists, Dietitians, and any other persons who are not licensed physicians who are trained to assist under the general and special instructions provided by them. I further understand I may revoke this authorization at any time; and I hereby authorize the Gulf Coast Health Center, Inc. to furnish and/or obtain confidential medical records. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

I hereby authorize Gulf Coast Health Center, Inc. to furnish information to insurance carriers concerning this illness/accident, and I hereby assign to the Center all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

I certify the information which I have provided to Gulf Coast Health Center, Inc. is complete and accurate to the best of my ability and knowledge.

_____

Signature (firma) Date (fecha)

PRIVACY POLICY

As a Gulf Coast Health Center, Inc. patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide quality health care for you. Please read this statement and ask us questions, if you have any.

The law requires that Gulf Coast Health Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

□ I have read or had explained to me Gulf Coast Health Center, Inc. Notice of Privacy Practices and Patient & Center Rights and Responsibilities and agree to continue my care with Gulf Coast Health Center, Inc. under said terms.
□ I was given the opportunity to read Gulf Coast Health Center, Inc. Notice of Privacy Practices and Patient & Center Rights and Responsibilities and declined but wish to continue my care with Gulf Coast Health Center, Inc. under said terms.
□ I have read or had explained to me Gulf Coast Health Center, Inc. Notice of Privacy Practices and Patient & Center Rights and Responsibilities and do not wish to continue my care with Gulf Coast Health Center, Inc. under said terms.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____

Signature (firma) Date (fecha)