Humboldt IPA

Priority Care Program

A GUIDE FOR YOUR HEALTH, WELLNESS AND SAFETY

AFTER HOURS CARE – holidays, weekends, nights

1. IF YOU ARE HAVING AN EMERGENCY, CALL 911 IMMEDIATELY.
2. If your issue is not an emergency but you need to speak to someone for advice or assistance before the Center is open again, please call our office number 707-442-0478. Your call will be forwarded to the answering service who will be able to reach someone for you to talk to.
3. Our normal business hours are Monday through Friday, 8 am to 5 pm. WE CLOSE FOR LUNCH FROM 12:30-1:30 daily.

PRESCRIPTION REFILLS

Please CALL YOUR PHARMACY to request refills of routine medications. The pharmacy will then transmit a refill request to us electronically. Please allow 72 hours for your refill to be processed and request further ahead if you know that you will need a refill over a weekend or holiday.

NEW PATIENTS: Please bring your medication bottles with you to your first visit.

HONESTY IS THE BEST POLICY

We promise to be honest with you about your health and wellness. In turn we ask that you are honest with us, particularly about your medical history and about your intentions to follow through with the plans we develop together to achieve and maintain your best possible health and wellness.

LAB AND X-RAY RESULTS

Please let us know with a phone call – leaving a message is fine – that you have had the x-rays, procedures, or labs ordered for you. We will then know to be watching for the results and we will call you to let you know what those results are.

TEAMWORK

We at the Priority Care Center (PCC) work together and we consider you to be part of our team. We appreciate any feedback you have for us. When you have a question or concern, you may be hearing back from any one of the PCC team members who has the expertise to assist you. Our team members include professionals from these programs:

- Primary Care/Care Transitions
- Care Coordination
- Wellness Coaching
- Diabetic Education
- Mental and Behavioral Health

Section 1—Demographic Information

Primary Care Physician:	How were you referred:	
Name (Last, First, M.I.):	A.K.A.:	
Date of Birth: / /	Age:	Gender: ☐Male ☐Female ☐Transgender ☐Other
Mailing Address:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
E-mail Address:	Do we have permission to contact you via e-mail? ☐ Yes ☐ No	

Primary Spoken Language:

- English ☐
- Spanish ☐
- Portuguese ☐
- Other:

To which racial or ethnic group(s) do you *most* identify:

- African-American (non-Hispanic) ☐
- Asian/Pacific Islanders ☐
- Caucasian (non-Hispanic) ☐
- Latino or Hispanic ☐
- Native American or Aleut ☐
- Other:

Marital Status: Single Partnered Married Separated Divorced Widowed	Full name of spouse or significant other:	
Employer Name:	Employer Address: Occupation:	
Employment Status (choose all that apply): Full-time Part-time Self-employed Not employed Retired Active Military		Driver's License Number:

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:	
Address:		
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Secondary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Other Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to for The Priority Care Center to obtain my prescription history.

Signature_____ Date_____/_____/_____

Name_____ DOB _____

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Name: _____ DOB: _____ Gender: ☐M ☐F

Primary Care Provider: _____

Preferred Pharmacy: _____Location: _____

CURRENT MEDICATIONS/SUPPLEMENTS (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

Past Medical History (Check all that apply)

☐ Acid Reflux/GERD	□ Chronic Pain	□ High Blood Pressure
□ ADHD	□ Depression	□ High Cholesterol
□ Alcoholism	□ Diabetes	□ Irritable Bowel
□ Allergies	□ Emphysema/Bronchitis/COPD	□ Kidney Disease
□ Anemia	□ Epilepsy/Seizure Disorder	□ Liver Disease
□ Anxiety	□ Glaucoma/Cataracts	☐ Osteoporosis
□ Arthritis	□ Headaches	□ Stroke
□ Asthma	□ Hearing Loss	□ Thyroid Disease
☐ Bleeding Disorders	□ Heart Disease	□ Other: _____
□ Cancer		

Allergies

□ No Known Allergies	□ Medication Allergies	□ Environmental/ Seasonal Allergies	□ Latex Allergy

List Allergies	Reaction

Name_____ DOB _____

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Past Surgical History

Date of Surgery	Type of Surgery

Family Medical History

Members	Status (Alive/Deceased)	Diabetes	High blood pressure	Heart Disease	Mental Illness	Cancer (Type)	High cholesterol	Unknown
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								
Children								

Social History

Tobacco Use: Current use: ☐Yes ☐No
Past Use: ☐Yes ☐No When did you quit? _____
Type: ☐Cigarettes ☐Cigars ☐Chew ☐E-cigarette
Recreational Drug Use: ☐Yes ☐No
Type: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamine ☐Other_____
Alcohol Use: ☐Daily ☐4-5 times per week ☐1-3 times per week ☐less than one time per week ☐none
Type: ☐Beer ☐Wine ☐Liquor
Marital Status: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
Living Situation: ☐Own ☐Rent ☐Homeless ☐Other _____
Children: ☐Yes ☐No if yes, do they live with you ☐Yes ☐No
Support Network: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other _____
Diet/Exercise: Are you on a special diet? ☐Yes ☐No if yes, what type _____
Do you Exercise? ☐Yes ☐No If yes, how often ☐Daily ☐3-5 days per week
☐1-2 days per week ☐less than once per week
What type _____

Name_____ DOB _____

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Do you have an Advance Directive in place?
☐Living Will ☐Durable Power of Attorney ☐Advanced Directive ☐POLST ☐None

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients			
Last Tetanus Booster	□ Within past 10 years	□ More than 10 years ago	□ Unknown
Last Eye Exam (Dilated or Retinal) Last Hearing Exam Last Dental Exam Last Foot Exam	Date: _____ Date: _____ Date: _____ Date: _____	□ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal	□ Unknown □ Unknown □ Unknown □ Unknown
Last colonoscopy/ sigmoidoscopy/Or stool test	Date: _____	□ Normal □ Abnormal	□ Unknown
Last DEXA Bone Scan Last Pneumonia Vaccine Flu shot this season?	Date: _____ Date: _____ □ Yes □ No	□ Normal □ Abnormal	□ Unknown
Women Only			
Last Pap Smear	Date: _____	□ Normal □ Abnormal	□ Unknown
Last Mammogram	Date:	□ Normal □ Abnormal	□ Unknown

Concerns
Please indicate any concerns regarding your health in the space provided

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NAME: _____

Date: _____

PHQ-9	*Over the **last 2 weeks** how often have you been bothered by any of the following problems?*	*not at all*	*several days*	*more than half the days*	*nearly every day*
1.	Little interest or pleasure in doing things	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4.	Feeling tired or having little energy	☐	☐	☐	☐
5.	Poor appetite or overeating	☐	☐	☐	☐
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9.	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
	PHQ-9 total score =				

Would you like someone from our office to contact you before your appointment regarding any of the above?

☐ **Yes** ☐ **No**

Are you currently undergoing any treatment for depression?

☐ **Medications:** _____

☐ **Counselor:** _____

☐ **Other:** _____

Client Name: _____ DOB: _____ Date obtained: _____

(PROMIS) Patient Reported Outcomes Measurement Information System is a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

Global Health Assessment

Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).

Questions	Excellent (5)	Very Good (4)	Good (3)	Fair (2)	Poor (1)
Global 01: In General, would you say your health is	☐	☐	☐	☐	☐
Global 02: In general, would you say your quality of life is	☐	☐	☐	☐	☐
Global 03: In general, how would you rate your physical health?	☐	☐	☐	☐	☐
Global 04: In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
Global 05: In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.	☐	☐	☐	☐	☐
	Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐	☐	☐	☐	☐
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐	☐	☐	☐	☐
	None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08: How would you rate your fatigue on Average?	☐	☐	☐	☐	☐
Global 07: How would you rate your pain on average?	☐ 0	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9	☐ 10
To be completed by staff: Total Score (G03, 06, 07, 08) Total Score (G02, 04, 05, 10)					_____