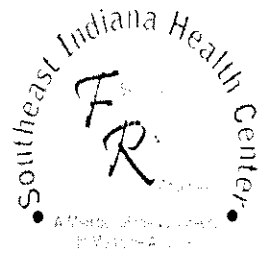

920 County Line Road. Suite B.
Batesville, Indiana 47006

Registration Form

Name:_____ Today's Date:_____
First Middle Last

Sex: Female _____ Male _____ Date of Birth:____/_____/_____

Responsible Person, **Parent Guardian Caregiver** (If not the patient. Please circle one)

Address: _____ City:_____

State:_____ Zip code:_____

County: Ripley Franklin (Please Circle)

Primary Telephone Number :_____

Other Telephone Numbers (Inc work or cell) :_____

Number of persons in patient household:_____ (including Children)

Are you covered by any health benefit program. (including Medicaid or health insurance)

Yes____No____ Please describe if Yes: _____

Patients Social Security:_____/_____/_____

Emergency Contact:
Name of person to contact in the event of an emergency:

_____ Relationship to patient :_____

Address:_____

Phone Number:_____

Please List below information for all people living within the household.

Family Members name	Age	Relationship	Employer Phone #	Pay Frequency

Financial Information

Monthly Income (gross) $_____Place of employment:_____

Previous Income (Patient) Last 3 months $_____ Last 12 months $_____

Household Income Last 3 months $_____ Last 12 Months $_____

Please list any other sources of income, (including benefits)

_____

Patient Signature_____ Date :_____

I understand the information I submit is subject to verification and subject to review by federal and/or state enforcement agencies and others as required. Under penalty of perjury, I affirm the above information is true and accurate. I also understand if I fail to provide the requested information, my eligibility for services at Southeast Indiana Health Center will not be granted. If during my treatment at SEIHC, I am referred for testing I hereby apply for the MMH Charity Care Assistance program.

920 County Line Road Suite B.
Batesville, Indiana 47006

Release Form

For and in consideration of the medical treatment and / or consultation made available to me without charge on the premise of the Southeast Indiana Health Center, I hereby agree to the following terms:

1. I hereby grant the **Southeast Indiana Health Center** full and unrestricted access to all of my health records, regardless of their present location and / or of whose custody the health records are currently in.

2. I hereby release, relieve and discharge from all liability the **Southeast Indiana Health Center**, its officers, directors, agents, employees and volunteers both professional and non professional of and from all liability for any losses, injuries of damages to either my person or to my property, occasioned by, in any manner growing out of, or as a direct or indirect result of my receipt of any diagnosis, consultation, procedures, medications, treatment or advice upon the premises of the **Southeast Indiana Health Center**. Or by anyone providing any such diagnosis, consultation, procedures, medications, treatment of advice in which the **Southeast Indiana Health Center** has any responsibility of is made available by it.

3. I hereby give my permission for the **Southeast Indiana Health Center**, it's agents, employees and volunteers to treat me during this clinic visit and to provide drugs, medical care and other service and supplies as are needed for my health and well being. I acknowledge that no representations, warranties of guarantees as to results or cures have been made to me by the **Southeast Indiana Health Center** nor have I relied upon any such representation, warranties or guarantees.

By my signature below, I certify that I have read this release (or have had the same read to me) and Fully understand its previsions.
I now voluntarily sign this release in evidence of my intent and agreement to be bound by it this _____day of_____,20_____.

_____ _____

Patient /Representative Signature Relationship **Printed Name**

_____ _____

Witness **Printed Name**

920 County Line Road, Suite B
Batesville, Indiana 47006

Medical Information & Privacy Notice

I,_____ hereby authorize the staff of Southeast Indiana Health Center to give the following person or persons all information concerning my health and well being.

_____ Spouse / Significant Other Name:_____

_____ Any Specified Person Name:_____

_____ I may be contacted by mail with issues regarding my health

_____ You may leave a message on my answering machine / voice mail

Other :_____

I understand I may revoke this consent at any given time, by giving written notice to the person or organization making the disclosure

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policy, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. Further, I permit a copy of this authorization to be used in place of the original.

Signed:_____ Date:_____

Witness:_____ Date:_____

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Occupation: _____

Marital Status: _____Single _____Married _____Widowed

Parent/Guardian: _____ Relationship_____

Have you or any of your blood relatives had any of the following? If yes, please explain.

Brain Disorders (anemia, clots, hemophilia, etc.) ____Yes ____No Please explain:
_____

Respiratory/Breathing Issues (asthma, COPD, etc.) ____Yes ____No Please explain:
_____

Heart Disease (high blood pressure, high cholesterol,Heart Valve) __Yes ____No Please explain:_____

Blood Disorders (anemia, clots, hemophilia, etc.) ____Yes ____No Please explain: _____

Liver Disease (hepatitis, cirrhosis, etc.) ____Yes ____No Please explain: _____

Pancreatic Disease ____Yes ____No Please explain: _____

Stomach Disorders (ulcers, GERD, etc.) ____Yes ____No Please explain: _____

Bowel Disorders (IBS, Crohn's, diverticulitis, etc.) ____Yes ____No Please explain: _____

Urinary/Kidney Disorders (UTI's, kidney stones, etc.) ____Yes ____No Please explain: _____

Nerve Disorders ____Yes ____No Please explain: _____

Mood/Mental Health Disorders ____Yes ____No Please explain: _____

Endocrine Disorders (diabetes, thyroid) ____Yes ____No Please explain: _____

Skin Disorders ____Yes ____No Please explain: _____

Autoimmune Disorders (multiple sclerosis, etc.) ____Yes ____No Please explain: _____

Bone/Joint Disorders (osteoporosis, gout, etc. Incl Joint Replacements ____Yes ____No Please explain: _____

Cancers of any kind ____Yes ____No Please explain: _____

Significant Infections (HIV/AIDS, STD, tuberculosis, etc.) ____Yes ____No Please explain: _____

Genetic Disorders (down syndrome, spina bifida, etc.) ____Yes ____No Please explain: _____

Other ____Yes ____No Please explain: _____

Surgeries/Procedures/Illness/Injury

List any past surgeries, procedures or hospitalizations you have had including the dates, as well as any issues you've experienced with anesthesia.

Surgery/Procedure/Illness/Injury: _____ Date: _____

Surgery/Procedure/Illness/Injury: _____ Date: _____

Surgery/Procedure/Illness/Injury: _____ Date: _____

Medications (List any prescription/non-prescription medications you use or have recently used. Medications include vitamins, nutritional supplements, oral contraceptives, pain relievers and cold medications.)

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Medication: _____ Dose (In Milligrams): _____ Times taken per day: _____

Allergies (Please list any allergies you have and the reactions that took place.)

Medication/Food/Substance: _____ Reaction: _____

Social History

_____Current Smoker – Number of packs per day: _____ Number of years smoking: _____

_____Former Smoker – When did you quit: _____ Number of pack per day: _____ Number of years smoking: _____

_____Drink Alcohol – How often: _____Seldom _____Occasionally _____Frequent _____ Daily

_____Recreational Drugs-How often: _____Seldom _____Occasionally _____Frequent _____ Daily

If so, how much, what type? _____

_____Caffeine-How often: _____Seldom _____Occasionally _____Frequent _____ Daily

Do you feel safe at home? _____Yes _____No

Do you or have you traveled outside of the United States? _____Yes _____No

How many times have you been pregnant? _____ How many children have you delivered? _____

How many miscarriages or abortions have you had? _____Number of living children _____

Birth Control used ? _____ Please Speak with medical provider if interested in seeking birth control

Immunizations (Please list the dates you received the below immunizations, if applicable.)

Tetanus: _____Hepatitis B: _____

Pneumonia: _____ Influenza: _____

Preventive Health Care (Indicate approximate dates of any of the following procedures you may have had.)

Women	Men
____Pap Smear: _____	____Rectal Exam: _____
____Mammogram: _____	____Prostate Specific Antigen (PSA): _____
____Bone Density: _____	____Colonoscopy: _____

Do you perform self breast exams or testicular exams when applicable? _____Yes _____No

The above information is accurate to the best of my knowledge.

Patient signature: _____Date: _____

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA), (See 28 U.S.C. §§ 1346(b), 2401(b), 2671-80) provides the exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by any free clinic volunteer health care practitioner, board member, officer, employee, or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. This FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee, or independent contractor who have provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic (See 42 U.S.C. § 233(a), (o)).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.

Acknowledged:

_____ (Patient signature)

_____ (Patient name, printed legibly)

_____ Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

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____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.