Non-Profit Integrated Community Health Center
430 Main Street, Bethel / PO Box 1908 Bethel, AK 99559
Ph: (907)543-3773 Fax: (907)543-3545
www.bethelfamilyclinic.org

Patient Registration Record:

Last Name:____________________First Name:________________________ Middle Name: _______________

SSN:______________________Date of Birth:______________________Marital Status: M W D S

Mailing Address:_________________________City:_____________State:_________Zip:________________

Physical Address:__________________________City:______________State:________Zip: _______________

Home Phone: __________________ Work Phone: __________________ Cell Phone: __________________

Preferred Method of Communication:____Home____Work____Cell

Email Address:_____________________________Employer:______________________Date of Hire: _____________

Occupation:________________________________

Patient Demographic Information:

Our federal grant requires us to collect and report on this information. The information is reported on the population as a whole, not by specific individual.

RACE: **(Please Check)** ___ White ____Black/African American ____ Alaska Native/American Indian

_____Asian ____Native Hawaiian ____Other Pacific Islander
_____Other ____Unknown _____More than one race

Ethnic Identity:_____Hispanic/ Latino ___Other
Veteran:____Yes No Veteran Status:_______________ Yes No (have you been discharged from the U.S military?)
Primary Language:_____English ____ Other: please identify_______________________________________
Interpreter Required? ☐ Yes ☐ No

Gender Identity: **(Please Check)** ___Male_____Female
__Female-to-male/ Transgender/Trans Man __Male-to Female (MTF)/Transgender Female/Trans Woman

__Gender queer, neither exclusively male nor female __Additional Gender Category/ (or other), please specify

__Decline to Answer

Sexual Orientation: __Lesbian, Gay, or homosexual __Straight or Heterosexual
___Bisexual ___Something else____Don't Know____Decline to Answer

Emergency Contact:
First/Last Name:_______________________________________Relationship to patient: _________________________

Emer. Contact Phone: _____________________ Date of Birth: ___________________ Revised: June21-BFC2

Insurance Information

Is this a work related injury?____Yes___No Date of injury_________Employer: ____________________________

Primary Insurance Information:

Insurance Company:____________________________Policy #_______________________Group#________________________

Policy Holder Name:_________________________Policy Holder DOB:__________________Gender:____Male____Female

SSN:____________________Relationship to Patient:________________________Policy Holder Employer: _______________

Policy Holder Phone: ___________________________________

Secondary Insurance Information:

Insurance Company:____________________________Policy #_______________________Group#________________________

Policy Holder Name:_________________________Policy Holder DOB:__________________Gender:____Male____Female

SSN:____________________Relationship to Patient:________________________Policy Holder Employer: _______________

Policy Holder Phone: ___________________________________

Family Size:______________________________ Annual Household Income: ______________________

Sliding Fee Discount Program

Bethel Family Clinic offers a sliding scale discount based on family size and income.
Please complete the sliding scale discount application form to determine your eligibility.

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the Bethel Family Clinic. I understand that I am financially responsible for amounts not covered by my insurance or beneficiary status.

I hereby consent for the Bethel Family Clinic to administer treatments and to perform medical or procedures as necessary.

Signature:____**Date:** _______________________________________
(Patient, Parent or Guardian)

Privacy Practices Acknowledgement:
I have received the Notice of Privacy Practices and I have been provided an opportunity to review the Notice.

Print Name:____

Signature:____**Date:** _______________________________________

Revised: June21-BFC2

Medical History Sheet

Patient Name:______________________________________**Date of Birth:** ______________________________________
General Physician:___________________________________**Referring Physician:** ______________________________
Reason for Today's Visit: ____
Medical History: (please mark all you have ever been treated for or are currently being treated)

No Medical History

General
- Bleeding Disorder
- Glaucoma
- HIV/AIDS
- MRSA
- Rheumatic Fever
- Systemic Lupus Erythematosus
- Transplant Recipient, Organ:______________

Cardiovascular
- Aortic Abnormality:____________________
- Atrial Fibrillation
- Blood Transfusion, Date:_________________
- Congestive Heart Failure
- Coronary Artery Disease
- Clot in Leg or Lung
- Heart Attack
- Heart Murmur
- Heart Valve Disorder, Type:___________________
- High Blood Pressure

Endocrine/Metabolic
- Diabetes
- Hyperthyroidism
- Low Testosterone

Respiratory
- Asthma
- COPD
- Emphysema
- Sleep Apnea
  - Use CPAP

Gastrointestinal
- Acid Reflux/GERD
- Crohn's Disease
- Hepatitis
- Stomach Ulcer
- Ulcerative Colitis

Genitourinary
- Chronic Kidney Disease
- Genital Herpes
- Genital Warts
- Interstitial Cystitis
- Kidney Stones
- Renal Failure
- STD: ______________________
- Urinary Tract Infections

Men's Health
- BPH
- Hydrocele / Spermatocele
- Prostatitis

Women's Health
- Endometriosis
- Uterine Fibroids

Musculoskeletal
- Arthritis
- Artificial Joints
- Chronic Back Pain
- Fibromyalgia
- Gout

Neuro/Psych
- Alzheimer's Disease
- Anxiety
- Parkinson's Disease
- Multiple Sclerosis
- Psychiatric Diagnosis: _______________
- Spinal Cord Injury, Level: _____________
- Stroke /TIA

Cancer
- Bladder
- Colon/ Rectal
- Female, Type: ____________________
- Penile
- Prostate
- Testicular
- Other: _____________

Immunizations:

Is the patient up to date on immunizations? Yes No

Female Health History:

Date of Last Menstrual Period: ________________________ Post-Menopausal: Yes No

Pregnancies# ________ Live Births: ____________ Abortions (elective or spontaneous) #________

Male Health History:

Date of Last PSA : ______________

Date of Last Prostate Exam: __________________ Normal _________________ Abnormal __________________

Recent Studies or Labs:

What:________________________________Where:_____________________________When:_________________________

What:________________________________Where:_____________________________When: ________________________

Surgical History: (please list ALL surgeries you have ever had) * If additional space needed, please ask.

Vasectomy Date:_____________________ Hysterectomy Date: ______________________

____Date: ________________________________

____Date: ________________________________

____Date: ________________________________

Social History: (check appropriate response)

*Marital Status:*____Single _____Divorced # of children: ________

___Married _____Widowed

Current Alcohol Consumption: No Yes ______drink/s per day

History of Alcohol Abuse: No Yes ______days/ months/ years sober

Current Tobacco Use: No Yes cigarettes/ cigars /chew ______packs per day

History of Tobacco Use: No Yes Age Start? _________ Age Stop? ____________

Recreational Drug Use:

____None______Current, name substance(s) ____

____Former, Name substance(s) ____

Daily Fluid Intake:

____8 oz. cups of coffee per day _______8oz. glasses of tea per day

____8oz. glasses of milk per day _______8oz. glasses of water per day

Patient Signature:____Date:_____________________________

Nurse/ MA Signature:____Date: _____________________________

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Pharmacy Information

Do you have an Account with any Pharmacy: ____Yes ____No
If yes, Please provide the following:
Preferred Pharmacy Name: ________________________________
Pharmacy Telephone: ____________________________________
Complete Address of Pharmacy: ____________________________
If no, a list of pharmacies will be provided to you. **It is your responsibility to create your account and notify the clinic.**
Note: *If you want uninterrupted medication issues, you need to notify us* ***14 days*** *in advance in order for your medication to arrive on time.*

Bethel Family Clinic is a Dispensary, NOT a pharmacy
We only dispense Medication in-house on initial prescriptions, Emergencies and Extenuating circumstances

1. **You as the patient have the right to refuse any medication suggested by the provider**.
2. Being a dispensary and not a pharmacy means insurance plans do not cover the cost of medications prescribed from BFC's in-house stock.
3. All medications that are dispensed in-house are the responsibility of the patient. Whether if medication is covered by their insurance, or whether they are used or not.
4. Before authorizing any medications we may require lab test, a visit with the provider, vitals or diagnostics testing as required by provider on a case basis.
5. After your initial prescription, you are required to set up a mail order pharmacy.
6. Look at your insurance card to determine if you're insurance has a preferred pharmacy.
7. If you don't have a preferred pharmacy you can chose your own. We have a list available for your use.
8. Contact BFC and ask for a nurse and inform them of which pharmacy and that your account is created.
9. Call your pharmacy between 48 & 72 hours after notifying the clinic that your accounts have been created.
10. Set up text or email alerts with your pharmacy.
11. Once pharmacy has received the prescription, wait up to 2 weeks to arrive in your mailbox.
12. If you do not receive your medicine within 2 weeks, please call your mail order pharmacy before calling BFC.

Print First/Last name:________________________________ Date of Birth: ________________

Patient signature:___________________________________ Date: _____________________

Non-Profit Integrated Community Health Center

Patient Medication List

Patient Name:____Date:_____/_____/_______

Preferred Pharmacy: ____

We only dispense Medication in-house on initial prescriptions, Emergencies and Extenuating circumstances.
Being a dispensary and not a pharmacy means insurance plans do not cover the cost of medications prescribed from BFC's in-house stock.

(Please include Prescription, Vitamins, and Over-the-counter Medications)

Medication	Dose	Time of Day (morning, noon, night)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Allergies

(Please list all known allergies, reactions and cause)

No known Drug Allergies

1.
2.
3.
4.
5.

Revised: June21-BFC2

Name:____ Today's Date:______________

Review of Systems

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health, In each area. If you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed. PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your provider.

Health In General No Problem Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:________________________________

Ears, Nose, Mouth & Throat No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:________________________________

C-V (Heart & Blood Vessels) No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:____________________

Resp. (Lungs & Breathing) No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:____________________________

GI (Stomach & Intestines) No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:_____________________

GU (Kidney & Bladder) No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other:____________________

MS (Muscles, Bones, Joints) No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:____________________

Integ. (Skin, Hair & Breast) No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:____________

Neurologic (Brain & Nerves) No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes or visual loss. Other:____________________

Psychiatric (Mood & Thinking) No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:____________

Endocrinologic (Glands) No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other:________________

Hematologic (Blood/Lymph) No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:________________

Allergic/Immunologic No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:____________________________

Relationship	Alive or deceased	Age	No Known Problems	Arthritis	Asthma	Autism	Birth Defects	Cancer	COPD	Depression	Early Death	Hearing Loss	Heart Disease	Premature CHD	High Blood Pressure	High Cholesterol	Kidney Disease	Learning Disability	Mental Illness	Developmental Disability	Miscarriage/Still Born	Stroke	Substance Abuse	Vision Loss	Other
Mother	A D																								
Father	A D																								
Sibling 1	A D																								
Sibling 2	A D																								
Child 1	A D																								
Child 2	A D																								
Maternal Aunt	A D																								
Maternal Uncle	A D																								
Paternal Aunt	A D																								
Paternal Uncle	A D																								
Maternal Grandmother	A D																								
Maternal Grandfather	A D																								
Paternal Grandmother	A D																								
Paternal Grandfather	A D																								