



**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](http://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: \_\_\_\_\_

**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 Scale 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.**

For more information and on the program, please ask the front desk for the application for the sliding discount fee scale application today.

I hereby decline to be considered for the Sliding Discount Fee Scale program at Bethel Family Clinic.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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:** \_\_\_\_\_



## 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 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 milk per day  
\_\_\_ 8oz. glasses of tea per day \_\_\_\_\_ 8oz. glasses of water per day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Nurse/ MA Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**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](http://www.bethelfamilyclinic.org)

---

**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 (X or Initials)

1.
2.
3.
4.
5.

Revised: May21-BFC1

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.

**Const. (Health in General)**       No Problems    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 of 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: \_\_\_\_\_

Revised: May21-BFC1

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 Delay	Miscarriage/Still born	Stroke	Substantial Abuse	Vision Loss	Other
Mother																									
Father																									
Sister																									
Brother																									
Daughter																									
Son																									
Maternal Aunt																									
Maternal Uncle																									
Paternal Aunt																									
Paternal Uncle																									
Maternal Grandmother																									
Maternal Grandfather																									
Paternal Grandmother																									
Paternal Grandfather																									



**THIS IS TO BE COMPLETED FOR ALL NEW MEDICAL AND BEHAVIORAL HEALTH PATIENTS AND THEN AGAIN EVERY 3 MONTHS.**



**Bethel Family Clinic**

P.O. Box 1908  
Bethel, Alaska 99559  
(907) 543-3773 Fax (907) 543-3545

**Encounter #:**

**DATE:**

**ALCOHOL USE DISORDER IDENTIFICATION TOOL-SBIRT**

We're going to ask you some questions about your alcohol use during the past year. We are asking all of our patients these questions because we know that alcohol use can affect many areas of health- and may interfere with certain medications. Please try to be as honest and accurate as you can be.

SBIRT Pre-Screen	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4x / month	2-3x/week	4 or more x/week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2 Note: "a bottle" of 750 ml=17 drinks	3-4	5-6	7-9	10 or more
3. How often do you have 4 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

**POSITIVE IF FEMALE IS GREATER THAN 3// POSITIVE IF MALE IS GREATER THAN 4  
IF POSITIVE. ASK REMAINING QUESTIONS. IF NEGATIVE. STOP HERE.**

4. How often during the last year have you found that you weren't able to stop drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you ben unable to remember what happened because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor or other person been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

\*Positive if total score is equal to or greater than 7 for all females & for men age 65+

\*Positive if total score is equal to or greater than 8 for males under 65

\*Positive if total score is equal to or greater than 5 for patients under 21

\*Positive if total score is equal to or greater than 1 for pregnant women

\*Total score 20 or greater may indicate dependence

**TOTAL SCORE  
(questions 1-10)**

**Action taken:**

Patient refused screening     Negative score- no further action necessary     Positive score- informed provider

**\*\*AFTER ACTION IS TAKEN, SCAN INTO PATIENT'S CHART AND GIVE PAPER COPY TO BH\*\***

BILL CPT CODE 99408 IF POSITIVE, PATIENT SAW MEDICAL PROVIDER & WAS GIVEN EDUCATION OR INTERVENTION. MEDICAL PROVIDER IS RESPONSIBLE FOR INDICATING THIS ON BILLING SHEET

**THIS IS TO BE COMPLETED FOR ALL NEW MEDICAL AND BEHAVIORAL HEALTH PATIENTS AND THEN AGAIN EVERY 3 MONTHS.**



**Bethel Family Clinic**  
 P.O. Box 1908  
 Bethel, Alaska 99559  
 (907) 543-3773 Fax (907) 543-3545

**Encounter #:**  
**DATE:**

**DRUG ABUSE SCREENING TOOL- 10**

We're going to ask you some questions about drug use during the past year(12 months). We are asking all of our patients these questions because we know that drug use can affect many areas of health- and may interfere with certain medications. Please try to be as honest and accurate as you can be.

In the past 12 months	No	Yes
1. Have you used drugs other than those required and prescribed by a doctor for medical reasons?	0	1
2. Have you abused more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If you've never used drugs, answer "0")	0	1
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? (If you've never use drugs, answer "0")	0	1
6. Do your spouse/parents/family/friends ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of drug use?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experience withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of drug use? (memory loss, ulcers, abscesses, hepatitis, convulsions, seizures, bleeding, etc)	0	1

**TOTAL SCORE:**

POSITIVE = ANY SCORE MORE THAN ZERO

DAST 10- Score	Degree of Problems Related to Drug Use	Action Needed
0	No problems reported	No action at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Comprehensive assessment
9-10	Severe level	Comprehensive assessment

**Action taken: (CHECK ONE BOX)**

- Patient refused screening       Negative score- no further action necessary       Positive score- informed provider

**\*\*AFTER ACTION IS TAKEN, SCAN INTO PATIENT'S CHART AND GIVE PAPER COPY TO BH\*\***

BILL CPT CODE 99408 IF POSITIVE, PATIENT SAW MEDICAL PROVIDER & WAS GIVEN EDUCATION OR INTERVENTION. MEDICAL PROVIDER IS RESPONSIBLE FOR INDICATING THIS ON BILLING SHEET

# 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 pleasures 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 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>