# PATIENT DEMOGRAPHICS

## PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

SEX:___M ___F DOB:_____/_____/_____ RACE:_____

ADDRESS:_____ APT/LOT/TRLR#_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME #:(_____)_____ CELL#:(_____)_____

PREFERRED LANGUAGE:_____

## PREFERRED METHOD OF CONTACT

HM# ☐ CELL# ☐

## PREFERRED PHARMACY

PHARMACY NAME: _____

PHARMACY LOCATION: _____

## EMERGENCY CONTACT INFORMATION:

NAME:_____

RELATIONSHIP:_____

PHONE NUMBER: _____

# GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

**NOTIFICATION**: _____
(Name of Health Department)

(Hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous written authorization has been given.

**DISCLAIMER ON SCREENING:** The Department uses screening tests, which are a way to find people who may develop certain common medical problems. Screening tests are valuable because they can find disease early-before it becomes a big health problem. Screening tests do not cover all diseases and may miss some diseases they are supposed to find, so the test results are not final, just one part of a complete exam. Screening tests can alert you to promptly get a medical check-up and treatment from a doctor or health clinic of your choice.

**GENERAL CONSENT:** I give permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests (which may include HIV testing), give injections, medications, and other treatments, and render other health services to the patient identified on this form.

**ADDITIONAL CONSENT:** In addition to the above general consent, I understand that special consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations and family planning methods.

**PRIVACY NOTICE:** I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice.

**QUESTIONS:** I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction.

**SIGNATURES:** Fill blank lines with NA if not applicable.

Patient's Name _____ Patient's Signature_____

Person Authorized to Consent (if not patient) _____ Relationship_____

Signature _____ Date_____

I decline HIV testing at this time. If so, initial here: _____

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**SIGNATURES SECTION II:** I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name _____

Name of Person Giving Consent _____Signature_____

Relationship to Patient _____ Date_____

Address _____

Phone Number_____

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**SIGNATURES SECTION III:**

Counselor Signature _____ Date_____

Name/Nombre: _____

DOB/Fecha de Nacimiento: _____/_____/_____

Date/Fecha: _____/_____/_____

**READ & INITIAL EACH POLICY STATING AGREEMENT:**

**Use and Disclosure of PHI with Other Providers for Continuation of Care**

_____I have received the Notice of Privacy Practices and understand that when I receive care at Denton County Public Health personal information about my health, treatment, and payment for services will be received, created, and maintained. I understand that my information will not be used or disclosed without my written authorization (permission) **EXCEPT** as described in the Notice of Privacy Practices that explains that Denton County Public Health may use and disclose my health information without authorization for (i) treatment, (ii) payment, and (iii) healthcare operation purposes. I understand that this includes using and/or sharing my health information with other health care providers that are, and may have been, involved in my care.

**Client Responsibilities for Referrals to Specialists**

_____ In order to maintain our relationship with specialists, please make sure you keep your appointments. I understand that if I am referred to a specialist, it is my responsibility to keep my appointment. Denton County Public Health will only authorize payment for the initial consultation if I am referred to a specialist. Any testing, procedures, surgeries, or follow-up appointments will be my responsibility. I must contact the office at least 24hrs prior, to reschedule my appointment if I am unable to keep it. The new appointment must be within a two-month period to allow **Denton County Public Health** to make appropriate arrangements for payment. I understand that if I do not call and fail to show up to the appointment, I will be responsible for full payment to the specialist if I make another appointment.

**Denton County Public Health Policy on Termination of Services**

_____ It is the policy of Denton County Public Health that a client may be terminated if the client is medically noncompliant, disruptive, unruly, threatening, or uncooperative to the extent that the client seriously impairs the staff's ability to provide services or if the client's behavior jeopardizes the safety of themselves, clinic staff, or other clients. Clients will be terminated after their 3rd no-show to their appointments in a year or if there is a pattern of cancelling or rescheduling appointments (5 or more during a year).

**Medication Policy**

_____ **Beginning January 01, 2014** you will be required to bring all your medications with you to each appointment. Medications include: all prescriptions written by a physician, all over the counter non-prescription medications, vitamins, and supplements. If you do not bring your medications with you, you will be asked to reschedule your appointment.

# STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION

I understand protected health information (PHI) is information that identifies me. The purpose of this authorization is to allow Denton County Public Health to share my protected health information as defined below.

## A. PATIENT INFORMATION

**Name**: _____ **Date of Birth**: _____

**Preferred method of contact:**

( ) Home Phone: _____ Leave detailed message: (Yes) ____ (No) ____
( ) Cell Phone: _____ Leave detailed message: (Yes) ____ (No) ____
( ) Email: _____

## B. EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____

Relationship to patient: _____

## C. AUTHORIZATION TO SHARE MEDICAL INFORMATION WITH FAMILY AND FRIENDS

In order for us to discuss or disclose any medical information to your family and friends we must have a signed consent on file allowing us to share information about your care. Please list the names of those you would like to involve in your health care. This information can be changed or revoked at anytime with your permission. If you DO NOT want to share any information with others, put N/A.

| | Family/Friend Name | Phone Number | Relationship |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |

## D. INFORMATION TO BE SHARED (Check the boxes of the information you want to share):

☐ **Entire Medical Record** (includes all records except Psychotherapy Notes)

☐ Progress Notes
☐ Cardiology Report(s)
☐ History and Physical
☐ Physician's Orders
☐ Radiology Report(s) & Images
☐ Consultation Report
☐ Laboratory Report(s)
☐ Other: _____
☐ Operation Reports
☐ Pathology Reports
☐ Immunizations

**Your initials are required to share or release the following information with your family and friends:**

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse)
_____Genetic Information (including Genetic Test Results)
_____STI Test Results/Treatment
_____TB Test Results/Treatment
_____HIV/AIDS Test Results/Treatment

## E. EXPIRATION

When will this authorization expire? (***select one***)

☐ 12 months from date signed ☐ When authorization is withdrawn

☐ Other (specify date or event) _____

## F. ACKNOWLEDGEMENT & SIGNATURES

- I understand I may change this authorization at any time by writing to the address listed on this form and that I cannot restrict information that may have already been shared.
- I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.
- I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.
- I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request.
- I authorize Denton County Public Health to access past RX (prescription) history.

**X**_____ _____

**Signature of Individual (or Personal Representative)** **Date**

If signed by a Personal Representative, please specify relationship to the individual**:**

☐ Parent of minor ☐ Guardian ☐ Other _____

**X**_____

Printed Name of Personal Representative **(if applicable)**

## G. CONSENTING MINOR *(Complete this section ONLY if you are UNDER 18 years of age and the information in this section applies to you. If the information does not apply to you, leave it blank)*

A minor is a person under 18 years of age who has not been married and has never been declared an adult by the court. The Texas law (***Texas Family Code § 32.003 and § 32,004***) allows a minor to consent to treatment and release of medical information when the minor is:

- Under 18 years and on active duty with the armed forces;
- 16 years or older, lives on their own away from their parents, and manages all their financial affairs;
- Unmarried, pregnant, and treatment is related to pregnancy;
- Unmarried and is the parent of a child and has custody of the child;
- Treatment is for drug and chemical addiction or dependency;
- Treatment is for an infectious, contagious, or communicable disease, including screening for sexually transmitted diseases (STD) and HIV, that must be reported by law;
- Counseling is for suicide prevention, chemical addiction or dependency, or for sexual, physical, or emotional abuse.

**X**_____ _____

Signature of Consenting Minor Date

**X**_____

Name & Relationship of Individual who helped you fill out this form (if applicable)

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# INFORMED CONSENT TO USE THE DENTON COUNTY PUBLIC HEALTH PATIENT PORTAL

The Patient Portal is a secure, internet-based messaging system that permits you to privately access your medical information and test results maintained by Denton County Public Health (DCPH). The website conforms and complies with the federal law HIPAA (Health Insurance Portability and Accountability). Data is encrypted, which safeguards against any unauthorized use. Only you will have authorized access, using your unique username and password. E-mail addresses, usernames and passwords are never shared by DCPH with other parties.

**If you wish to participate in this voluntary service:**

1). Read, sign and date this consent form acknowledging you understand and agree to our policy. This must be witnessed and attested to by our staff.
2). Provide us with your written, secure e-mail contact information.
3). You will then receive an e-mail with a unique identification and temporary password, through our electronic medical records vendor *eClinicalworks*.
4). Log in to the Portal website link in the e-mail with your user name and temporary password.
5). Once you are logged in you will have an opportunity to create a new password, and view your test results.

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By reading, completing and signing this form I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. **I Decline Patient Portal Consent** ☐

My username and password will not be shared with others, and it is my responsibility to protect these from access by unauthorized persons.

Use of the Denton County Patient Portal System is contingent upon my maintaining satisfactory status as an active patient in DCPH clinics, and this access may be revoked or disabled without prior notification.

To continue patient Portal access, I agree to notify DCPH of any future changes in my e-mail address. I understand that my review and written consent must be updated if/when this policy is modified in the future.

Patient/Guardian Signature:_____Date: _____

Patient name: _____DOB: _____

Staff Witness:_____Date: _____

Confidential e-mail address (print clearly)_____

**If the patient is a minor** enter name of Parent/Guardian requesting access:

Parent/Guardian: _____Date: _____

Staff Witness:_____Date: _____

Allergies and Current Medication: Ever had a reaction to any drug, medication, including local anesthesia?

Y N

If yes, name:_____

**Personal Medical History**

Do you now or have you ever Had disease of:

**Circle**

1) Y N Heart
2) Y N Gallbladder/Liver
3) Y N Nerves/Depression
4) Y N Stomach/Bowel
5) Y N Blood Pressure
6) Y N Cancer
7) Y N Migraines
8) Y N Diabetes
9) Y N Fainting
10) Y N Seizures
11) Y N Skin/Bones
12) Y N Joints
13) Y N Lungs/Asthma/TB
14) Y N Elevated Cholesterol
15) Y N Kidneys/Bladder
16) Y N Lead Exposure
17) Y N Thyroid
18) When was your last Tetanus Shot? Date_____

**Family History Relation**

19) Y N Diabetes
20) Y N Heart Attack
21) Y N Stroke before 60
22) Y N High Cholesterol
23) Y N High Blood Presseure
24) Y N Birth Defects
25) Y N Genetic Problems
26) Y N Cancer
27) Y N Bone Disease
28) Y N Osteoporosis

**Gynecologic History**

29) Age Periods Began_____

30) Last period Started On:

_____

31) Y N Do you use condoms?

32) What method of birth control do you use?

_____

33) How often is your period?

**Circle**

34) Y N Are you Pregnant?
35) Are you having sex?

*Have you experienced recently?*

36) Y N constipation?
37) Y N Diarrhea?
38) Y N Emotional changes?
39) Y N Cramps?
40) Y N Vaginal Bleeding after sex?
41) Y N Vaginal Bleeding between menstrual periods?
42) Y N Hot Flashes?
43) Y N Vaginal discharge?
44) Y N Vaginal Itching?
45) Y N Vaginal Dryness?

**Have You Been Treated For:**

46) Y N Gonorrhea
47) Y N Chlamydia
48) Y N Genital Herpes
49) Y N Genital Warts
50) Y N Syphilis
51) Y N Pelvic Inflammatory Disease?
52) Y N Endometriosis?
53) Y N Ovarian Cyst/Fibroids?
54) Y N Abnormal pap?

When?

_____

**Social History**

55) Highest grade completed:

_____

*Have you recently experienced:*

**Circle**

56) Y N Emotional/ Relationship Changes?
57) Y N Death of a Family Member/Friend?
58) Y N Job Loss/Financial Problems?
59) Y N Problems with Living Arrangements/School?
60) Y N Legal Problems/Arrest/Divorce?
61) Y N Parental Problems?
62) Y N Has anyone Forced you to have sex?
63) Y N Has anyone hit, Slapped, Kicked, or Hurt you?
64) Y N Are you afraid of your Partner/Family Member?
65) Y N Do you have Someone that supports you with your problems?
66) Y N Are you on a special diet?
67) Y N Do you Smoke?
68) Number of cigarettes:

_____

69) Do you Drink Alcoholic Drinks?
70) Number per week _____
71) Y N Have you changed partners in the last 6 months?
72) Y N Have you used street drugs?
    Type: _____
    When: _____

73) Were any of your partners a street drug user, Hemophiliac, or infected with HIV/AIDS or Hepatitis?
    Y N
74) Age of first intercourse: _____
75) Do you have:
    - o Vaginal Sex
    - o Oral sex
    - o Anal Sex
76) How many different people have you had sex with?

    Male: _____
    Female: _____

TEXAS Health and Human Services | Texas Department of State Health Services

# TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
# ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

**Consent for Registration and Release of Immunization Records to Authorized Persons / Entities**

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

**Please mark the appropriate box to indicate whether you are a <u>First Responder</u> or an <u>Immediate Family Member</u>.**

☐ I am a **<u>FIRST RESPONDER</u>**. ☐ I am an **<u>IMMEDIATE FAMILY MEMBER</u>** (older than 18 years of age) of a First Responder.

By my signature below, I **<u>GRANT</u>** consent for registration. I wish to **<u>INCLUDE</u>** my information in the Texas immunization registry.

**Individual (or individual's legally authorized representative):** _____ Printed Name

_____ Date _____ Signature

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

**Questions?** (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
**Texas Department of State Health Services • ImmTrac2 Group - MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347**

**PROVIDERS REGISTERED WITH ImmTrac2:** Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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Denton County PUBLIC HEALTH

# Immunization Patient Eligibility Screening: Adult

Today's Date: ____ / ____ / ____
month day year

Patient Name: _____
Last First

Patient's Date of Birth: ____ / ____ / ____ ☐ Male ☐ Female
month day year

County of Residence: _____ Veteran: ☐ Yes ☐ No

Please **check the box** for the category that applies.
Sign and date at the bottom.

| The patient... | |
|---|---|
| Has NO health insurance | ☐ |
| Has Adult Medicaid / Healthy Texas Women or CHIP Perinatal | ☐ |
| Has private health insurance or Medicare | ☐ |

Check here if you are 19 years of age and have been referred to our clinic to finish a vaccine series you began when you were 18 or younger and eligible for Texas Vaccines for Children (TVFC) ☐

Referring Provider: _____

*NOTE: Knowingly falsifying information on this document constitutes fraud.*
*By signing this form, I hereby attest that the information above is true and correct.*

PATIENT SIGNATURE: _____ DATE: _____

Important Information for Former Military Service Members:
Women and men who served in any branch of the United States Armed Forces, including Army, Navy, Marines, Air Force, Coast Guard, Reserves or National Guard may be eligible for additional benefits and services. For more information, please visit the Texas Veterans Portal at www.veterans.portal.texas.gov.

| *Clerical Staff Use Only: Program Eligibility* | |
|---|---|
| ASN | Private Flu/Travel |
| | |
| Verified By (staff initials): _____ | |

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Denton County PUBLIC HEALTH

# Screening Checklist for Contraindications to Vaccines for Adults

Patient name _____

Date of birth _____ /_____ /_____
month day year

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Are you sick today? (including fever over 100.4)<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 3. Have you ever had a serious reaction after receiving a vaccination?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 5. Do you, or does a close family member, have cancer, leukemia, HIV/AIDS, or any other immune system problem?<br>a. If Yes, please explain who: | ☐ | ☐ | ☐ |
| 6. In the past 3 months,have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 7. Have you had a seizure or a brain or other nervous system problem? (e.g. Guillain-Barré Syndrome)<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | ☐ | ☐ | ☐ |
| 10. Have you received any vaccinations or a TB (tuberculosis) test in the past 4 weeks?<br>a. If Yes, please explain: | ☐ | ☐ | ☐ |

**FORM COMPLETED BY** _____ **DATE**_____

**FORM REVIEWED BY** _____ **DATE** _____

**Did you bring your immunization record card with you?** **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.