UCSF Benioff Children's Physicians

Adult Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information		
Patient Name (Last, First):		**Date of Birth (DOB):**
Marital Status:	**Sex:**	**SSN:**
Home Address:		
Home Phone #:	**Cell Phone #:**	
Email Address:		
What is your preferred language?	**Would you like an interpreter?** ☐ Yes ☐ No	
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	**Are you currently employed?** ☐ Yes ☐ No If yes**, Employer Name**: **Employment Status:** ☐ Full Time ☐ Part Time	
Name of Primary Care Provider (PCP):		

Emergency Contacts	
In **case of an emergency**, please provide the names of **individuals** (e.g. spouse or friend) we should contact below:	
(1) Emergency Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Aunt/Uncle ☐ Brother/Sister ☐ Other Relative ☐ Caregiver ☐ Friend
(2) Emergency Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Aunt/Uncle ☐ Brother/Sister ☐ Other Relative ☐ Caregiver ☐ Friend

Primary Insurance Information	
Name of primary health insurance coverage plan:	
Policy ID #:	**Group #:**

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Who is the primary subscriber of the plan? ☐ Me ☐ (1) Emergency Contact ☐ (2) Emergency Contact ☐ Someone Else		
If 'Someone Else' please provide their **name and address**:		
Relationship to Patient: ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Other Relative		
Home and/or Cell Phone #:	Is the **subscriber** currently employed? ☐ Yes ☐ No	
Subscriber's Employer Name:	☐ Full Time ☐ Part Time ☐ Retired	
Subscriber's DOB:	**Sex:**	**SSN:**

Secondary Insurance Information

Name of secondary health insurance coverage plan:		
Policy ID #:	**Group #:**	
Who is the primary subscriber of the secondary plan? ☐ Me ☐ (1) Emergency Contact ☐ (2) Emergency Contact ☐ Someone Else		
If 'Someone Else' please provide their **name and address**:		
Relationship to Patient: ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Other Relative		
Home and/or Cell Phone #:	Is the **subscriber** currently employed? ☐ Yes ☐ No	
Subscriber's Employer Name:	☐ Full Time ☐ Part Time ☐ Retired	
Subscriber's DOB:	**Sex:**	**SSN:**

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure	
Name of Referring Provider:	
If pregnant, what is your **Expected Due Date (EDD)?**	☐ Singleton ☐ Twins ☐ Multiples

What is the Name and Address of Your Preferred Pharmacy and Lab?

Patient Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

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We Ask Because We Care

Please complete this questionnaire. We use this information to review the treatment patients receive and to ensure that everyone gets the highest quality of care. Your individual responses are private and will not be shared outside the health care system.

1. Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to answer ☐ Unknown

2. How would you describe your Race? By race, we mean the major world group or groups from which your ancestors came. *Please check as many categories as you need to describe yourself.*

   ☐ American Indian/Alaska Native
   ☐ African American/Black
   ☐ Native Hawaiian/Other Pacific Islander
   ☐ Asian
   ☐ White
   ☐ Decline to Answer
   ☐ Unknown
   ☐ Other_____

3. How would you describe your Ethnicity? By ethnicity, we mean the group or groups with whom you share your cultural identity or customs. *Please check as many categories as you need to describe yourself.*

   ☐ African
   ☐ African American/Black
   ☐ Alaska Native
   ☐ American Indian
   ☐ Arab/North African
   ☐ Asian Indian
   ☐ Cambodian
   ☐ First Nation (Canada)
   ☐ Caribbean/West Indian
   ☐ Central American
   ☐ Chinese
   ☐ European/European Descent
   ☐ Filipino
   ☐ Guamanian
   ☐ Hmong
   ☐ Indigena - Maya
   ☐ Japanese
   ☐ Korean
   ☐ Laotian
   ☐ Mexican
   ☐ Middle Eastern
   ☐ Mongolian
   ☐ Native Hawaiian
   ☐ Pacific Islander
   ☐ Russian
   ☐ Samoan/American Samoan
   ☐ South American
   ☐ Thai
   ☐ Tibetan
   ☐ Tongan
   ☐ Vietnamese

   ☐ Decline to Answer ☐ Unknown ☐ Other_____

4. In which state and/or country were you born? _____

Please hand this form back to the front desk staff when completed. Thank you.

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Adult Patient Health History Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information	
Patient Name (Last, First):	**Date of Birth (DOB):**
What is the reason for today's visit?	

Gynecology/Obstetric Health History		
Date of Last Menstrual Period (LMP):		
Do you currently experiencing of the following: ☐ Pelvic Pain ☐ Bleeding ☐ Cramping ☐ Nausea ☐ Vomiting ☐ Fever ☐ Chills		
Have you or your partner traveled to an area affected by the Zika virus in the last 6 months? ☐ Yes ☐ No		
If pregnant, **Expected Due Date (EDD):**	☐ Single ☐ Twins ☐ Multiples	
If pregnant, is your pregnancy **co-managed?** ☐ Yes ☐ No	If yes, please provide the **name of the provider**:	
Have you had a **previous ultrasound** visit? ☐ Yes ☐ No	If yes, **when and where** was the ultrasound visit?	
Date of last pap smear exam:		
Please provide the *total* amount for each of the following:		
# of pregnancies:	# of vaginal deliveries:	# of cesareans:
# of miscarriages:	# of ectopic pregnancies:	# of abortions:
# of pre-term births:	# of living children:	# of multiple gestation deliveries:
Have you ever had any of the following?		
Abnormal pap smear result? ☐ Yes ☐ No	**If yes,** what was the **date and form** of treatment?	
Sexually Transmitted Disease (STD)? ☐ Yes ☐ No	**If yes**, what was the type and form of treatment?	
Hormone replacement therapy? ☐ Yes ☐ No	Abnormal periods? ☐ Yes ☐ No	
Are you currently **sexually active?** ☐ Yes ☐ No	# of sexual partners **in lifetime**:	
# of sexual partners in the **last year**:	Sex of sexual partners: ☐ Male ☐ Female ☐ Both	
Contraception method: ☐ Condoms ☐ Diaphragm ☐ Cervical Cap ☐ IUD/Implant/Patch ☐ Pills ☐ None		
Do you experience pain during **sexual intercourse?** ☐ Yes ☐ No		

General Health History
Are you currently being treated for any medical problems? ☐ Yes ☐ No
Please check if you currently have or had of the following: ☐ High Blood Pressure ☐ Stroke ☐ Urine Infections ☐ Kidney Disease ☐ Liver Disease ☐ Asthma ☐ Bleeding Disorders ☐ Heart Disease ☐ Blood Clots ☐ Psychiatric Disorders/Depression/Anxiety ☐ Other (please specify):

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☐ Cancer	Type of Cancer:	☐ Diabetes	Type of Diabetes:
Colonoscopy Date & Results:		Mammogram Date & Results:	

Past surgeries (include type and date):

Past hospitalizations or blood transfusions (include type and date):

Current allergies:

Current prescribed medications (include dosage and frequency, for more space use the back of this page):

Family Health History

Please complete if a member of your family currently has or had a medical complication, disease or disorder:

Family Member	Type of Complication, Disease or Disorder (ex. Colon Cancer, Bipolar Disorder, Depression, etc.)
Mother	
Father	
Sister/Brother	
Aunt/Uncle	
Maternal Grandparent	
Paternal Grandparent	

Please check if you or your partner OR family members have or had any of the following:

☐ Birth Defects ☐ Mental Retardation ☐ Congenital Heart Defects ☐ Down Syndrome ☐ Hearing/Vision Loss
☐ Spina Bifida/Anencephaly ☐ Cystic Fibrosis ☐ Muscular Dystrophy ☐ Sickle Cell Disease/Trait
☐ Thalassemia ☐ Metabolic Disorder ☐ Mediterranean/Asian/Ashkenazi/French Canadian/Cajun Ethnicity

Social History

Current or past occupation:

With whom do you live (include pets if applicable)?

Please check if you **currently or have consumed** any of the following:
☐ Cigarettes ☐ (Chewing) Tobacco ☐ Cigars ☐ Alcohol ☐ Drugs (please provide type):_____

Regarding the above, **how often?** ☐ Never ☐ Rarely ☐ Socially ☐ Moderately ☐ Very frequently

How often do you exercise?	**For how long?**
☐ 0 – 3 times a week ☐ 4+ times a week	☐ 10 – 30 min per session ☐ 30+ min per session

Anything else you would like the provider to know?

Thank you! Please hand this form to the medical staff when you are roomed.

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given access to a copy of the UCSF Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact a clinic representative. Also, a copy is posted on our website at www.UBCP.org.

Printed Patient Name | Date of Birth (DOB)

If Patient is a Minor, Printed Parent/Legal Guardian or Financial Guarantor Name

Relationship to Patient

Signature of Patient or Parent/Legal Guardian | Today's Date (Date Noticed Received)

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Terms and Conditions of Registration, Medical Services and Financial Agreement

1. UCSF Benioff Children's Physicians (UBCP) is part of the University and is comprised of its hospital(s), medical center(s), its hospital-based clinics, and the UCSF School of Medicine.
2. **MEDICAL CONSENT:** I consent to medical treatments or procedures x-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping and laboratory procedures.
3. **RELEASE OF MEDICAL INFORMATION:** The State of California information Practices Act requires UBCP to provide the following information to individuals who supply information about themselves. As a patient of UBCP, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UBCP is authorized to maintain this information. As required by UBCP, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage. UBCP will obtain my written authorization to release information about my medical treatment, except in those circumstances when UBCP is permitted or required by law to release information (see UBCP's Notice of Privacy Practices for a description of the specific circumstances under which UBCP may release this information). For example, UBCP may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in California, UBCP is required by law to report my diagnosis to the State Department of Health Services.
4. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay, co-insurance or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay UBCP for professional and clinic services. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.
5. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UBCP of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UBCP, including emergency services, at a rate not to exceed UBCP actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UBCP by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service:

Printed Patient Name	**Today's Date**
Signature of Patient or Witness (required if patient unable to sign)	**Today's Date**
Witness Relationship to Patient	
Signature of Interpreter (if applicable)	**Today's Date**
Language Used	