NORTH PENN
10255 N PENN AVE,
OKLAHOMA CITY, OK 73120
405.749.0800

MIDTOWN
222 NW 12TH STREET,
OKLAHOMA CITY, OK 73103
405.232.8631

Patient Name:		MRN#:
☐ Medical	☐ Vision	☐ Dental

Which Crossings Community Clinic site(s) are you applying to?

☐ Crossings Community Clinic-Penn
10255 North Pennsylvania Avenue
Oklahoma City, OK 73120

☐ Crossings Community Clinic-Midtown
222 Northwest 12th Street
Oklahoma City, OK 73103

How did you hear about Crossings Community Clinic?

☐ Family/Friend ☐ Internet ☐ 411 ☐ Other: ___________________________

Are you currently receiving care with a different clinic/doctor?

☐ No ☐ Yes, where? ___________________________

1.) ☐	**NO FORMS OF INSURANCE** **Are you a U.S. Citizen? If so, apply for SoonerCare at oklahoma.gov and include a SoonerCare Denial Letter.)**
2.) ☐	**VALID PHOTO ID** **(Driver's License, Passport, or ID)**
3.) ☐	**RECENT UTILITY BILL** **(If the bill is not in your name, provide alternate mail in your name with current address.)**
4.) ☐	**PROOF OF HOUSEHOLD INCOME**

Most recent year's TAX RETURN for ALL MEMBERS of your household who earn money. You may also provide proof of income for the previous 60 days.

Any AWARD LETTERS OR CARDS that support your current state of financial need. Examples: Pay stubs for prior 60 days, W2, employer letter with hours worked and pay rate, social security, unemployment, housing or food assistance benefits (SNAP card), child or spousal support, workers' comp, disability, etc.

***Please note:** We partner with outside agencies to provide free or low-cost referrals to specialists, lab, and imaging services which are required for primary care. These agencies REQUIRE proof of income, so we must have current information on file. If you do not have the specific forms listed above, call the clinic and request to speak with someone about proof of income requirements, and complete the Self Declaration of Income Form.

Note: If you DO NOT have last year's tax return, you may need to provide updated financial information.

5.) ☐	**COMPLETED NEW PATIENT APPLICATION PACKET**

Registration form, Health History, Patient Rights and Responsibilities, Information/Privacy Acknowledgement, Consent for Services

For Office Use:	
Packet accepted by:	Date:
Packet accepted by:	Date:
Nurse review by:	Date:
☐ APPROVED/**Appt Date & Time:**	☐ DENIED/Reason:
Date: Note:	

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PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Full Legal Name: (Last, First, Middle)	Date of Birth: (MM/DD/YYYY)

Sex:	Marital Status:	Social Security Number: (XXX-XX-XXXX)
☐ Male ☐ Female	☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced ☐ Separated	

What is your race? (Check all that apply)	What is your ethnicity?
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other: ________________	☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary Language Spoken:
☐ English ☐ Spanish ☐ Other: __________________

Current Home Address: (City, State, Zip)	Homeless? ☐ Yes ☐ No

Email Address:	Home Phone Number: ( ) -	Cell Phone Number: ( ) -

EMERGENCY CONTACTS

Contact 1	Contact 2
Name: Relationship: Phone: OK to share medical information? ☐ Yes ☐ No	Name: Relationship: Phone: OK to share medical information? ☐ Yes ☐ No

LIVING SITUATION AND HOUSEHOLD FINANCIAL INFORMATION

How many adults (18 or over), including yourself, live in your home?	How many children (under 18), live in your home?

How many people in the home have an income of any kind? (including unemployment, disability, SSI, retirement income)

Total amount YOU earn for the household? $_______________ ☐ weekly ☐ every other week ☐ monthly ☐ yearly

COMBINED income earned by ALL members of the household?	DID YOU FILE TAXES FOR LAST YEAR?
$____________ ☐ weekly ☐ every other week ☐ monthly ☐ yearly	☐ Yes ☐ No ☐ Unsure
Are you employed? ☐ Yes- full time ☐ Yes- part time ☐ No	Employer Name:

ADDITIONAL INFORMATION

Have you been seen as a patient of Crossings Community Clinic or Good Shepherd Clinic before? ☐ Yes ☐ No

Primary Health Concern(s):

VISION care needs?	DENTAL care needs?	How long have you been without medical insurance?
☐ Yes ☐ No	☐ Yes ☐ No	Last doctor who cared for you regularly?

Preferred Pharmacy Name:	Pharmacy Phone Number:	Preferred Pharmacy Address:

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HEALTH HISTORY

BRING ALL MEDICATION IN ORIGINAL CONTAINER TO FIRST APPOINTMENT

MEDICATIONS (including herbals, birth control, and over-the-counter meds) ☐ None

	Name	Dose/Frequency	Taking	Not Taking	Need Refills
1			☐	☐	☐
2			☐	☐	☐
3			☐	☐	☐
4			☐	☐	☐
5			☐	☐	☐
6			☐	☐	☐
7			☐	☐	☐
8			☐	☐	☐
9			☐	☐	☐
10			☐	☐	☐
11			☐	☐	☐
12			☐	☐	☐
13			☐	☐	☐
14			☐	☐	☐
15			☐	☐	☐

ALLERGIES ☐ None

Food allergies: ___________________________________

Medication allergies: ______________________________

Are you allergic to Iodine or shellfish? ☐ Yes ☐ No

Are you allergic to Latex or rubber? ☐ Yes ☐ No

CURRENT AND PAST MEDICAL HISTORY (check all that apply) ☐ None

☐ Anxiety/Depression
☐ Anemia
☐ Asthma
☐ Allergies or Hay Fever
☐ Congenital Heart Disorder
☐ Cancer or Leukemia
☐ Dementia (memory loss)
☐ Diabetes
☐ Thyroid Disease
☐ Blood clots, DVT, Pulmonary Embolism
☐ Bone, Muscle or Joint Disorder
☐ Endocarditis
☐ Emphysema, COPD, Chronic Bronchitis
☐ Enlarged Heart or CHF
☐ Epilepsy, Seizures, Convulsions
☐ Headaches or Migraine
☐ Heart Attack or Chest Pain/Angina
☐ High Blood Pressure
☐ Heart Bypass, Angioplasty, Stents
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis, Jaundice or Liver Disease
☐ HIV positive or AIDS
☐ Heart Pacemaker or Defibrillator
☐ Irregular Heart Beat
☐ Kidney Disease / Dialysis
☐ Schizophrenia / Bipolar Disorder
☐ Sickle Cell Disease or Trait
☐ Skin Disorder
☐ Stroke
☐ Transplanted Organ
☐ Tuberculosis

Other: ____

SURGICAL HISTORY ☐ None

Month / Year	Type of Surgery

HOSPITALIZATIONS / ER VISITS ☐ None

Month / Year	Reason for Hospital Stay / ER Visit

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FAMILY HEALTH HISTORY

FAMILY HISTORY (check all that apply) ☐ **None / Unknown**

Family Member	Diabetes	High Blood Pressure	Heart Disease	Cancer	Asthma	Birth Defect	Mental Illness	Substance Abuse
Father	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Sibling-Sister/Brother	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Mother	☐	☐	☐	☐	☐	☐	☐	☐
Mother's Father	☐	☐	☐	☐	☐	☐	☐	☐
Father's Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father's Father	☐	☐	☐	☐	☐	☐	☐	☐

Other: ____

TOBACCO USE / SMOKING

Are you currently a smoker? ☐ **Yes** ☐ **No** ☐ **Former Smoker**

Do you smoke every day? ☐ Yes ☐ No

How many packs of cigarettes per day? ☐ Less than half a pack ☐ 1 pack ☐ More than one pack

How long since you last smoked? ☐ <1 month ☐ 3-6 months ☐ 7-12 months ☐ 1-5 years ☐ 6-10 years ☐ > 10 years

Do you use other forms of tobacco? *(check all that apply)*
☐ pipe ☐ snuff ☐ cigars ☐ chew ☐ e-cigarettes ☐ vape

How many years have you smoked?

Are you: ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

ALCOHOL USE

Do you drink alcohol? ☐ **Yes** ☐ **No**

If yes, how often do you drink? ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

How many drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more

SUBSTANCE USE

Have you used any non-medical drugs in the past 12 months? ☐ **Yes** ☐ **No**

If yes, which drug(s) (*including marijuana, medical or recreational*):

Are you still using? ☐ Yes ☐ No

How many months ago did you last use? ☐ <6 months ☐ 6-12 months ☐ 12-24 months ☐ 24+ months

SEXUAL HISTORY

Are you sexually active?
☐ **Yes, within the last month** ☐ **Yes, in the past**
☐ **Never been sexually active**

Do you have sex with?
☐ Men ☐ Women ☐ Both ☐ Neither

Do you use birth control/protection? ☐ Yes ☐ No

Do you have any history of sexually transmitted infections?
☐ Yes ☐ No

If yes, which infections?
☐ Chlamydia ☐ Gonorrhea ☐ HPV ☐ HIV
☐ Herpes ☐ Syphilis ☐ Trichomoniasis
☐ ______________________________

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WOMENS HEALTH HISTORY
Are you currently pregnant or breastfeeding? ☐ Yes ☐ No If yes, expected due date:
Do you have periods? ☐ Yes ☐ No If yes: ☐ Regular ☐ Irregular
Last well woman exam (month/year): Last mammogram (month/year): Any breast changes/lumps?
History of women's health concerns: (History of STD or pelvic infection / infertility / fibroids or cysts / abnormal pap / HPV / urinary incontinence) ☐ Yes ☐ No If yes, explain:
Obstetric History: Total number of pregnancies in your life: Total number of early losses (miscarriage or abortion): Total number of full-term births: Total number of premature births: Number of living children:

MENS HEALTH HISTORY
History of testicular trauma or surgery: ☐ Yes ☐ No
History of men's health concerns: (STD/STI / testicular pain or swelling / penile pain or discharge / visible sores / sexual difficulties) ☐ Yes ☐ No If yes, explain:
Year of last prostate/rectal exam:
Prostate Concerns: Any trouble urinating or emptying bladder? ☐ Yes ☐ No Waking at night to urinate? ☐ Yes ☐ No Blood in urine? ☐ Yes ☐ No Kidney/urine/prostate infection? ☐ Yes ☐ No Testicular pain or swelling with straining/lifting/or coughing? ☐ Yes ☐ No

OTHER
As a child, did you complete the recommended vaccination series? ☐ Yes ☐ No ☐ Unsure
Have you ever had any of the following illnesses? ☐ Yes (check all that apply) ☐ No ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Shingles ☐ Polio ☐ Rheumatic Fever
Have you had any of the following vaccines as an adult? ☐ Yes (check all that apply & write year) ☐ No ☐ Tetanus/Tdap/dTap _______ ☐ Flu _______ ☐ Pneumonia _______ ☐ COVID-19_______ ☐ Shingles ___________ ☐ Other _______
Do you have concerns about your diet? ☐ Yes ☐ No Explain:
Have you ever had a colonoscopy ☐ Yes ☐ No If yes, year:

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PATIENT RIGHTS AND RESPONSIBILITIES

Name: *(Last, First, M.I.)*	**DOB:**

Crossings Community Clinic believes in team-based health care. We each have a role to play.

Crossings Community Clinic is responsible for:

- Providing high-quality primary care services.
- Providing considerate and respectful care.
- Explaining all procedures and test results at patient appointments.
- Doing our best to respond to all calls and messages in a timely manner.
- Keeping all medical information private.

You, as a patient, are responsible for:

- Being on time for appointments. If you need to cancel or reschedule, you must call at least 24 hours before your appointment time at 405-749-0800 (North Penn) or 405-232-8631 (Midtown). Leaving a voicemail is acceptable. If you miss two (2) appointments in one year without calling, Crossings Community Clinic may discontinue care.
- Obtaining any lab testing or imaging that is ordered by your physician before your next appointment.
- Informing Crossings Community Clinic within 30 days of any changes to your insurance status, income, or contact information. Failure to do so may result in delayed treatment.
- Providing updated household financial information each year and as requested.
- Being an active partner in managing your health.
- Inappropriate/abusive language and behavior directed toward providers, staff, volunteers, or other patients is unacceptable. The clinic reserves the right to refuse care.
- ***If you do not speak English, <u>bring an interpreter</u> who is 18 years or older to all appointments.***

Patient Information:

- **Medications:** Crossings Community Clinic does not prescribe or dispense any narcotics or controlled substances. Please notify us before you run out of medication. There is no guarantee we will be able to fill walk-in medication requests.
- **Limitations:** Crossings Community Clinic is limited in the services which we provide to patients and cannot guarantee access to specialty referrals and imaging.
    - **Due to limited resources, Crossings Community Clinic is NOT able to:**
        - Treat emergency conditions.
        - Treat Workman's Comp injuries.
        - Establish social security disability.
        - Assist patients with court cases related to their medical condition.
        - Determine a patient's ability or inability to perform any type of work.

I HAVE READ AND UNDERSTAND THE PATIENT RIGHTS AND RESPONSIBILITIES DOCUMENT AND AGREE TO COMPLY WITH ALL OF ITS TERMS AND CONDITIONS.

Patient/Guardian Signature: ______________________________ Date: ________________

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PATIENT INFORMATION AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT

Name: *(Last, First, M.I.)*	DOB:

AUTHORIZATION TO CONVEY PERSONAL HEALTH INFORMATION BY MESSAGE

I authorize Crossings Community Clinic staff, providers, and volunteers to leave messages for me at the phone numbers I have provided as personal contact information. I understand that these messages could include Protected Health Information (PHI) pertaining to my appointment dates/times, care, and treatment and may come in the form of voicemail or text message.

I AUTHORIZE CROSSINGS COMMUNITY CLINIC TO LEAVE MESSAGES CONTAINING PROTECTED HEALTH INFORMATION IN THE FOLLOWING MANNER: (Select all that apply)

☐ Voicemail ☐ Text Message ☐ With Family/Friends ☐ **No Messages Please**

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION

I give permission for Crossings Community Clinic to provide my Protected Health Information to the following people:

NAME	RELATIONSHIP	PHONE NUMBER

I acknowledge and understand that this authorization will be kept as part of my medical record and will remain in effect until withdrawn by me in writing. It is my responsibility to inform Crossings Community Clinic if I want to change any of my contact information.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the opportunity to review the Crossings Community Clinic's Notice of Privacy Practices and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction. Ask a staff member to see a copy of the Notice of Privacy Practices.

______________________________ ______________

Parent/Guardian Signature **Date**

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CONSENT FOR SERVICES

Name: *(Last, First, M.I.)*	DOB:

Volunteer Immunity Act Statement of Disclosure and Acknowledgment

Oklahoma Law provides that certain health professionals are immune from liability in a civil action based on the acts or omissions in providing volunteer health professional services under certain circumstances one of which is that the volunteer health services were provided at a free clinic where neither the professional nor the clinic receives any form of compensation for any treatment provided at the clinic.

Except for some of the healthcare providers and administrative staff, most persons that will provide my care and services are volunteers. I understand I am giving up my right to recover for injuries or damages in a lawsuit against any volunteer health practitioner or the Crossings Community Clinic in exchange for receiving free health services.

Consent for Healthcare Treatment

Health services offered through Crossings Community Clinic may be administered by a variety of licensed health professionals and some services may be provided by a variety of non-licensed professionals, counselors or other clinicians, which may include health professionals in training or interns.

To ensure continuity of care, it may be necessary for Crossings Community Clinic to share information about me with other providers involved in my care.

Crossings Community Clinic may take and use photos, images, or videos of me and/or my minor child for the purposes of: inclusion in my health record, education, documenting current/future health status, sending to healthcare referral sources and others who would actively participate in my care, and to communicate with granting organizations.

I am aware that the practice of healthcare is not an exact science and acknowledge that no guarantees have been made to me concerning the results of any procedures and/or treatments performed. I acknowledge that even though my provider will seek to advise me of known risks involved with any treatments/procedures performed, additional unforeseeable and/or unpreventable situations could arise in the course of my care, which might result in harm.

I have read and understand the Consent for Services form. Questions have been answered to my satisfaction. Understanding the above, I give my consent to receive services from Crossings Community Clinic. My consent is valid until I withdraw it in writing.

Print Patient Name: ______________________________ Date: ________________

If patient is under age 18, print name of parent/legal guardian: ______________________________

Patient/Guardian Signature: ______________________________

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CANCELLATION AND NO SHOW NOTICE

Appointment Policy

Honor your scheduled appointments or notify us as early as possible, if you will miss your visit. This allows us to schedule another patient who will benefit from care.

Cancellations are considered a "No Show"

- Cancellation within 24 hours before appointment
- Cancellation at the time of appointment reminder
- Late arrival of 15 or more minutes after your appointment is scheduled
- Failure to show up for your scheduled appointment without notice

Reschedule Cancellation

- Your appointment will be rescheduled if advanced notice has been given.
- After TWO (2) No Shows, the Clinic may choose not to schedule another visit and may decide not to continue care.

Dental Extraction Clinic Cancellation/No Show

- After a No Show, your Dental record will be inactivated.

My signature below signifies I understand the Cancellation and No Show policies.

Name (print): ____

Signature: ____ Date: ________________________

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PATIENT COPY

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