GALLIA COUNTY HEALTH DEPARTMENT
Primary Care / Reproductive Health & Wellness Clinic

Name ____
(Last) (First) (MI) (Maiden)

Address____
(Street) (City) (State) (Zip)

Date of Birth______________________________ Age _______ Social Security Number ______________________

Home Phone _________________ Cell Phone __________________ Consent to Call? __Yes __No Text? __Yes __No

Parent/Guardian Name (If applicable) ________________________ County of residence:________________________

Would you like access to the Patient Portal? __Yes __No Email____

Emergency contact Name _________________________ Relationship to Patient _____________________________

Emergency Contact Phone Number ___________________________________

Race: (Please circle) White; Black; Asian/Pacific Islander; Native American; Biracial; Other (Specify) ___________________

Ethnicity: Non-Hispanic___ Hispanic ___

Primary Language ______________________

Marital Status: (Please circle) Single; Married; Separated; Divorced; Widowed

Number of People in your household __________ Are you currently a student? __Yes __No

Highest grade of school completed ______ Occupation __________________________________

Place of Work _____________________________________ Work Phone ______________________

How did you hear about us? ______________________ Preferred Pharmacy? ______________________________

*Please complete the table below to the best of your ability.

	Household member/Relationship	**Source of Income**	**Amount of Income** (per week, month or year)
1.			
2.			
3.			

Do you have private insurance? __ Yes __ No Do you have a medical card? __ Yes __ No

If you have insurance, we will need a copy of the insurance card.

Initial here if you consent to the Release of Billing Information and Assignment of Benefits related to obtaining payment for this visit, and understand you may receive additional statements for services not covered by your insurance(s):________

If uninsured and being seen through the Reproductive Health & Wellness Program, a sliding fee scale will be used to determine your costs; however, services will not be denied due to an inability to pay.
If uninsured and being seen through the Primary Care Clinic, there will be an office visit fee of $35.00. There will be additional fees for labs, if needed.

*Primary Reason for visit today: ____

Health History

ALLERGIES (List anything that you are allergic to: medications, food, bee stings, etc.)

____

MEDICATIONS (Please list all the medications you are taking - Include prescribed and over-the-counter drugs)

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		

Additional meds: ____

PAST MEDICAL HISTORY (Please check all that apply)

☐ ADD/ADHD	☐ Gout
☐ Acid Reflux (GERD)	☐ Heart Disease
☐ Anemia	☐ Heart Problems
☐ Anxiety Disorder: ____________________	☐ Hepatitis
☐ Arthritis	☐ High Cholesterol
☐ Asthma	☐ History of STI
☐ Autoimmune Disease: ________________	☐ High Blood Pressure
☐ Blood diseases: _______________________	☐ Overactive Thyroid
☐ COPD	☐ Underactive Thyroid
☐ Cancer	☐ Infertility
☐ Congestive Heart Failure	☐ Kidney Disease
☐ Depression	☐ Kidney Stones
☐ Dermatologic (Skin) Disorders	☐ Mental Disorder/Illness
☐ Diabetes – Type 1	☐ Osteoporosis
☐ Diabetes – Type 2	☐ Polyps
☐ Diverticulitis	☐ Pulmonary Embolism
☐ Ear or Hearing Problems	☐ Seizures/Epilepsy
☐ Endometriosis	☐ Stroke
☐ GI Problems	☐ Trauma/Violence
☐ Blindness	☐ Vision or Eye Problems
☐ Other:	

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			

FAMILY HEALTH HISTORY

			SIGNIFICANT HEALTH PROBLEMS IN MY FAMILY									
RELATION	ALIVE?	AGE	ALCOHOLISM	ARTHRITIS	DEPRESSION	CANCER	DIABETES	GENETIC DISEASE	HEART DISEASE	HIGH BLOOD PRESSURE	OSTEOPOROSIS	STROKE
GRANDMOTHER (MATERNAL)	☐ Y ☐ N											
GRANDFATHER (MATERNAL)	☐ Y ☐ N											
GRANDMOTHER (PATERNAL)	☐ Y ☐ N											
GRANDFATHER (PATERNAL)	☐ Y ☐ N											
FATHER	☐ Y ☐ N											
MOTHER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
BROTHER/SISTER	☐ Y ☐ N											
OTHER:	☐ Y ☐ N											

ADDITIONAL HEALTH FACTS

Please add other information about your health that you would like your provider to know here:

SOCIAL HISTORY

Identify as: (Please circle) Male Female
Identify as: Straight Homosexual Bisexual Transgendered Pansexual Unknown
Are you sexually active? ___Yes ___ No If no, have you been sexually active in the past 6 months? Yes No
Do you use condoms? ___ Always ___Never ___Sometimes **Do you have multiple sexual partners?** ___Yes ___No
Do you drink alcohol? ___Yes ___ No **If yes, how much?** Occasional Moderate Heavy
At what age did you start drinking? ______
Do you use tobacco? ___Yes ___ No If yes, how much? __________________ # of years? _______
At what age did you start smoking? ______
Do you vape or use e-cigarettes? ___Yes ___ No Nicotine CBD OTHER
Do you use smokeless tobacco? Chew Snuff Moist Tobacco Powder
Do you currently use recreational or street drugs? __Yes __No List: _________________________________
Exercise Level? __None __Occasional __Moderate __High **Caffeine Intake:** # of cups/cans per day? ______
Do you use seatbelts? ___Yes ___ No **Do you use sunscreen?** ___Yes ___No
Diet: (Please circle) Regular Vegetarian Vegan Diabetic Gluten Free Other: ______________________________________
Stress Level? ___Low ___Medium ___High **Do you have a good support system?** ___Yes ___No
Do you experience emotional/relationship problems? ___Yes ___No
Is there anyone who often says hurtful/mean things? __Yes __No
Is there anyone who is physically abusive? ___Yes ___No If in the past, are you safe now? ______________________
Have you ever been diagnosed with depression or other mental health condition? __Yes __No
Do you ever have thoughts of hurting yourself or others? ___Yes ___No
Do you feel safe in your home? ___Yes ___No

For Women Only

Date of Last Menstrual Period? _______________ **Date of Last Pap Smear?** _______________ Abnormal ___ Normal ___
Age of First Menstrual Period? ____ **Have you gone through Menopause?** ___Yes ___No **Date of last Mammogram?** ________
Number of Pregnancies? _____ **Number of Living Children?** _____ **Concerned you may be pregnant?** ___Yes ___No
Do you want to have children (more children) someday? If yes, at what age? ___________
If no or not now, are you using birth control to prevent pregnancy? ___Yes ___No
What is your current birth control method? _____________________________________
Do you perform monthly self-breast exams? ___Yes ___No

For Men Only

Are you experiencing testicular problems? ___Yes ___No **Do you perform monthly testicular self-exams?** ___Yes ___No
How many children do you have? ___ **Do you want to have children (more children) someday?** ___Yes ___No
What is your or your partner's current birth control method? _____________________________________
Have you had a PSA Level in the past? ___Yes ___No **Prostate Present?** ___Yes ___No

For Pediatric (Under 18) Patients ONLY

Are you in Daycare? ___Yes ___No **Name of Daycare**: ____
Are you a student? ___Yes ___No Grade ____ **Name of School**: ____
Who do you live with? (Please circle) Both Parents Mother Father Grandparent Guardian Other: __________________
Parents' marriage status: _____________________ **How many siblings do you have?** ____________
Are you involved in sports? If yes, list sport(s): ____
Have you had a lead screening? ___Yes ___No **Does someone in the household smoke?** ___ Yes ___ No
Do you see a dentist? ____Yes ____No **Do you brush your teeth 2 times/day?** ___Yes ___No
Do you experience bullying? ___Yes ___No **Seat belt/car seat used routinely?** ___Yes ___No
Are there any financial concerns in the home? ___Yes ___No

x ____ ____

Signature of patient or legal guardian **DATE**

Gallia County Health Department
Reproductive Health and Wellness Program/Primary Care Clinic

Consent for the Provision of Medical Services and to Obtain and/or Release Records

NAME OF PATIENT:___________________________________ **DATE OF BIRTH:**______________

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form. As a state/federally supported program, the Reproductive Health and Wellness Program is required to provide data to the Ohio Department of Health about the clients we serve and our clinic activities.

I have been given information about the test(s), treatment(s), procedure(s), to be provided including the benefits, risks, possible problem/complications and alternative choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services and services are received on a voluntary basis. I know that I can change my mind at any time. Receipt of family planning services is not a prerequisite of any other services offered.

Services will be provided in a confidential manner; however, I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as much as legally possible. A copy of the HIPPA guidelines will be provided to me at my request.

I hereby request that a person authorized by the Gallia County Health Department provide appropriate evaluation, testing, treatment (including birth control drug, if I request it).

I, ______________________________, understand the need for medical care and consent to the services provided
(PATIENT NAME)
by the Gallia County Reproductive Health & Wellness Clinic/Primary Care Clinic. These services include: social and educational services, laboratory procedures, medical treatment, examinations, diagnostic procedures and other services deemed necessary by the clinician. I have been told and understand that the services provided are for medical care only and do not include emergency services.

I give permission to **OBTAIN and/or RELEASE** my medical records to a Provider or organization concerned with providing further care or services to me. I release the staff of the Reproductive Health & Wellness Program/Primary Care Clinic from any liability resulting from disclosure of information in those medical records.

Patient Signature: ____________________________ Witness: ______________________________
Date: ____________________ Date: _____________________

If patient is a **minor under 18**:
Parent/Guardian Signature: ____________________________ Relationship: ______________________

For Under 18 Minors WITHOUT Parental Consent Only

I, ______________________________, a minor, have been told by the staff of the Gallia County Reproductive Health & Wellness Clinic the following: 1) the legal implications of not having the consent of a parent/guardian for care and services provided in this clinic. 2) that it is advisable to have written permission from a parent/guardian for the care and treatment provided in this clinic.

I do not, at this time, wish to inform my parent/guardian of my medical condition/pregnancy or of my involvement with the Reproductive Health & Wellness Program. The clinic staff has requested that I obtain the above-mentioned permission and I refuse to do so. This decision has been my own and I take full responsibility for my actions.

Patient: _________________________ Witness: _________________________ Date: __________________

Gallia County Health Department
Reproductive Health and Wellness Program/Primary Care Clinic

Assignment of Insurance Benefits/ Financial Responsibility

I authorize payment of my insurance benefits directly to the Gallia County Health Department. I understand that I am financially responsible for charges not covered by this authorization, and all bills not paid in a timely manner by my insurance carrier. I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls, and/or text messages to my mobile device and to any telephone number provided by me with this encounter from the Gallia County Health Department. I understand this consent includes without limitation, any account management companies and independent contractors, including without limitation, any debt collectors.

All cash pay visits for Primary Care are due at the time of service. If your appointment involves getting lab drawn, 50% of the lab cost are due at the time of the visit. If you are unable to pay the amount in full you will have 12 months to pay the amount in full. If the amount is not paid in full no appointments or labs will be performed until the previous amount is paid.

Any Reproductive visits will be applied to our sliding fee scale, based on your income and household size). There is a financial hardship program for Reproductive needs if needed, ask to discuss with a staff member.

For any Out-of-Network insurance e.g. (Ohio Medicare or VA) we will offer the cash pay option of a base fee of $35 Office Visit. If labs are drawn LabCorp will bill your insurance for the cost of labs.

Patient Name: ______________________________ **DATE OF BIRTH ______________**

Patient Signature: ___________________________ **Date: _____________**

Witness: ___________________________________ **Date: ______________**

Financial Policy Effective January 27, 2022