StFrances Cabrini Clinic
Most Holy Trinity Catholic Church

Patient Registration Form

Updated January 2023

1234 Porter St. Detroit MI-48226
Phone: 313 9617863 Fax: 18665286429

PERSONAL INFORMATION

Patient Legal Name: Last Name | Full Name | M.I.

Marital Status :

Date of Birth : / /

Prefered Language :

Biological Sex : Male Female Intersex

Gender Identity :

Race :

Ethnicity:

Address:

City/State :

Postal Code :

Phone Number :

Social Security:

Emergency Contact

Name:

Phone Number :

MEDICAL INFORMATION (you can write over grey text)

List your Current Medications in this Form: : Medicine Name (Dosage) - Frequency

Example: Tylenol (100 mg)- once daily

Allergies — No Known Allergies

Medication/Substance	Reaction
Medication/Substance	Reaction

Surgeries/Hospitalizations

Date	Hospital	Reason
Date	Hospital	Reason

HEALTH QUESTIONNAIRE

Do you have Medicaid, Medicare or Private Insurance? Yes No if Yes Type of Coverage

Are you a current or past user of tobacco? (cig, vape, chew etc.) Yes No if Yes Amount of Cigrettes Each Day | Start Date | Quit Date | Want to Quit?

Do you drink alcoholic beverages? Yes No if Yes Amount of Drinks per day | What Kind? | Current or Past | Want to Quit?

Are you a current or past user of recreational drugs? Yes No if Yes Amount Taken each day | What Kind? | Current or Past | Want to Quit?

Have you ever experienced violence or abuse? Yes No

Do you want to talk about it with a Counselor? Yes No

Are you sexually active? Yes No if yes, Partners: Male/Female/Both

Are you Hepatitis C vaccinated? Yes No

Do you want to discuss anything about your health habits, sexual activity, or health goals? Yes No

INDIVIDUALS OF FEMALE SEX ONLY

Date of Last Pap Smear / /

Have you had an abnormal Pap? Yes No

Date of Last Mammogram / /

Do you perform a monthly breast self-examination? Yes No

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FAMILY MEDICAL HISTORY

✓ **Tick mark for problems you and/or your family members had in the past or currently have**

BEHAVIORAL	Self	Mother	Father	Siblings	More Information (If needed)
Alcoholism/Substance Abuse					
Mental Health Problems					
Social Problems					
Mental Disabiltiy					
Eating Disorder					

CHRONIC	Self	Mother	Father	Siblings	More Information (If needed)
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Arthritis/Joint problems					
Obesity					
Epilepsy/Seizures					
Asthma					

ORGANS AND TISSUES	Self	Mother	Father	Siblings	More Information (If needed)
Dental Problems					
Kidney Problems					
Bowel/Bladder Problems					
Liver Disease/Hepatitis					
Thyroid Problems					
Respiratory Problems					
Blood disorder/ Sickle cell anemia					

MISCELLANEOUS	Self	Mother	Father	Siblings	More Information (If needed)
Sexually Transmitted Infections/ Diseases					
HIV/AIDS					
Rheumatic Fever					
Tuberculosis					

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ONLY FILL IF YOU FEEL YOU NEED ASSISTANCE WITH SOCIAL SERVICES

BASIC NEEDS ASSESSMENT Ask for this whenever you feel you need social support

Name _____ Phone Number _____

Zip Code _____ Email ID _____

Date of Birth : ☐☐ / ☐☐ / ☐☐

✔ **Tick mark how the following social needs are met by you**

SOCIAL NEEDS	FULLY MET	MOSTLY MET	PARTIAL MET	NOT MET	More Information (If needed)
Afforable Housing	1	2	3	4	
Food/Clothing	1	2	3	4	
Utility Assistance	1	2	3	4	
Legal Services	1	2	3	4	
Sexual Assault Intervention	1	2	3	4	
Employment/Training	1	2	3	4	
Domestic Violence Intervention	1	2	3	4	
Drug/Alcohol Intervention	1	2	3	4	
Mental Health Services	1	2	3	4	
Medical Insurance	1	2	3	4	
Other	1	2	3	4	

Answer these questions so that we can best assist you

Are you a US Citizen? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Are you of Protected Status? ☐ Yes ☐ No

Do you have a State ID or License? ☐ Yes ☐ No

How many Members in your House? 1 2 3 4 5

Are you fluent in English? ☐ Yes ☐ No

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Authorization for Medical Treatment

Read Carefully-This is a contract

I **consent** to receive services at **Cabrini Clinic**. This treatment may include **assessment, routine diagnostic procedures, medications, and such medical treatment** as the attending Physician/Nurse Practitioner/Physician's Assistant consider to be necessary for my care. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination and treatment at this clinic.

I understand that the services I receive at Cabrini Clinic, or as a result of a referral from Cabrini Clinic, are being provided by health care practitioners and lay volunteers who are not receiving compensation, and **compensation will not be requested from any source.** I understand, as provided by **Federal and Michigan State law**, that these volunteers are liable for civil acts or omissions amounting to gross negligence or willful and wanton misconduct or were intended to inure me.

PRIVACY & MEDICAL RECORDS: I understand that all medical information in my medical record will be held in confidence and **not released except with my written consent**. I understand that the **privacy and confidentiality** of my health information are **highly protected and treated with the utmost care**. I understand that Cabrini Clinic, which has a referral relationship with Henry Ford Hospital (HFH), may share my medical information related to the referral with HFH and obtain medical information from HFH to improve continuity and thoroughness of care.

My signature below constitutes my acknowledgment that I have understood this request for consent and that I agree to its terms and contents.

☐☐ / ☐☐ / ☐☐ _____ _____

DATE **PATIENT PRINTED NAME** **PATIENT SIGNATURE**

HIPAA Privacy and Release of Information Authorization

I, **(INSERT NAME)** hereby authorize **CABRINI CLINIC** and its affiliates, its employees, and agents, to use and **disclose protected health information** (eg., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me resolve claims and health benefit coverage issues.

I understand that any **personal health information** or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a **right to revoke this authorization** by providing **written notice**. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a **right** to have a **copy of this authorization**.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this **authorization is voluntary** and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been **advised** of this practice's Privacy practices, Release of Billing information policy, assignment of benefits policy, and grant the practice medication history authority.

if applicable, the Legal representative sign below:

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (eg. power of attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the member's behalf with respect to this authorization form.

☐☐ / ☐☐ / ☐☐ _____ _____

DATE **PATIENT PRINTED NAME** **PATIENT SIGNATURE**

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Eligibility Attestation (For Pharmacy Use)

PART 1: PARTICIPANT INCOME INFORMATION

I hereby attest that my current estimated annual income from wages is	$
Additional Income from sources such as social security disability income, workers' compensations, dividends, interest, assistance from family, friends or charity, public assistance and/or food stamps, or other sources:	$
Those Other Sources of Income Are:	$
Income for all other living in my household during the same 12 month period:	$
Number of Individuals in Household:	$
Total income from wages and all other sources:	$

PART 2: INSURANCE INFORMATION

I hereby attest that I am not covered by any form of prescription insurance, including Medicare, Medicaid VA Benfits, or other coverage

PART 3: SIGNATURE (REQUIRED)

I certify that all of the above infromation is true and accurate. I understand that this information is to be used to determine eligibility for the dispensary of Hope and its related access sites. I will notify staff of any changes in employment , income or insurance prior to having additional prescriptions filled.

__ __ / __ __ / __ __
DATE

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

_____
STAFF PRINTED NAME

_____
STAFF SIGNATURE

FOR PHARMACY USE ONLY (IGNORE): Please compare the total income in Part 1 above with the 2020 Federal Poverty Guidelines. Applicants must be at or below 200% of Federal Poverty Guidelines and either lack insuracne or are covered undere a plan with no prescription coverage. Pateints with Medicaid, Medicare, VA benifts, or other coverage are not eleigble for Dispensary of Hope medication.

Persons in family/household	Poverty Guideline	200% FPG	300%FPL (INSULIN ONLY)
1	$12760	$25520	$38280
2	$17740	$34480	$51720
3	$21720	$43440	$65160
4	$26200	$52400	$78600
5	$30680	$61360	$92040
6	$35160	$70320	$105480
7	$39640	$79280	$118920
8	$44120	$88240	$132360