BULLHOOK
Community Health Center

Sports Physical Intake Form

Patient's Legal Name (Last, First, MI)	Previous Names:	Preferred First Name

Mailing Address:	City:	State	Zip + 4
Physical Address:	**City:**	**State:**	**Zip + 4**

Home Phone:	Cell Phone:	Work Phone: ☐Yes contact me at work	Ext.

Email:

☐ Does not have Email ☐ Will not Disclose ☐ Other

Opting out of Text Message – Email

We are an automated practice with regular text messaging and email to provide helpful information to our patients like appointment reminders, clinic forms to fill out prior to appointments, patient statements and payments. Text messages and emails that contain health information are secured by a technical process called encryption and require identity verification. If you do not want to be contacted by Bullhook Community Health Center by text or email, please indicate below.

EMAIL:

☐ NO, please do not communicate with me by regular email. (Please note that by marking NO you will not be able to access patient portal services or telehealth services)

TEXT:

☐ NO, please do not communicate with me by regular text messaging.

DATE OF BIRTH:	**GENDER:** ☐ **Female** ☐ **Male**

Social Security Number:

Allergies:

_____

_____

_____

Emergency Contact Information

Contact full Name: ☐ Patient at Bullhook CHC	Contact Phone number:	Relationship to you?

Name (Last, MI, First)

Who is your primary care physician? (Who do you see for your primary medical care)

Physician's Name:	Facility:	Phone number:

☐ English is my preferred language ☐ I need translation in _____

What is your race or origin? (Check all that apply) ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Asian ☐Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian or Chamorro ☐ Samoan ☐ More than one race ☐ Choose not to disclose or report

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What is your ethnicity?
☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Another Hispanic, Latino or Spanish Origin Combined ☐ Not Hispanic, Latino or Spanish Origin ☐ Choose Not to Disclose or report

Employment Status					
☐ Student	☐ Part-Time				
EMPLOYER NAME:					
Employer Phone number:					

NOTICE OF PRIVACY PRACTICES:
I have received a copy of BCHC's Notice of Privacy Practices informing me of how my medical information may be used and disclosed. This document also explains how I can access medical information for myself and my dependents.
Signature: _____ *Date:* _____

Notice of Administrative Use of Confidential Health Care Information:

I have been informed and understand that:

1. Confidential health care information concerning me or the person for whom I am legally responsible for, are recorded in the course of receiving immunizations from this Health Facility in an electronical record and retained in the Montana Immunization Information System – imMTrax.
2. A Prescription History will be obtained concerning me or the person for whom I am legally responsible for, are recorded in the course of receiving care from this Health Facility in an electronical record and retained in Bullhook Community Health Center records unless I specifically direct otherwise.
3. Unless I specifically direct otherwise, the immunization information in imMTrax will be shared with all my immunization providers to help prevent both over- and under-immunization and to create a consolidated vaccine record for me or the person for whom I am legally responsible:
4. Any confidential health care information concerning me or the person for whom I am legally responsible may be used for the administration and direct provision of services that are to be provided to me or to the person for whom I am legally responsible.
5. Health Department and State health care and administrative personnel associated with the delivery of those services and the administration of the programs of services and the imMTrax data system may access the information as necessary for the provision and administration of services. Administration of services may include, but not limited to, the billing of insurers, scheduling of appointments, coordination immunizations, and facilitating enrollment in other programs; and
6. All persons who have access to this confidential information are obligated under federal and state law to protect the information from inappropriate disclosure.

TREATMENT/PAYMENT AGREEMENT FOR Bullhook Community Health Center, INC. (BCHC)

I request the Bullhook Community Health Center, Inc. provide me with medical, dental and/or behavior health care. I accept responsibility to pay for this care according to the fee schedule established. Furthermore, I authorize assignment of benefits for medical, dental and/or behavioral health services to be paid to BCHC. Also, I authorize BCHC to bill my insurance and release information to the insurance company if requested. I will communicate to BCHC any changes to my income and/or insurance status.

By signing below, I understand and give consent for my information to be accessed by outside entities for the purposes of auditing the facilities' compliance with federal, state, and pharmaceutical program business rules and I attest that the information provided is correct to the best of my knowledge.

_____ _____

Patient, Parent, or *Legal Guardian Signature — Date

*Please provide a copy of your legal guardianship paperwork

_____ _____

If signed by parent/legal guardian, please print name — Relationship to patient.