New Patient Information Form Truth's Community Clinic

Patient Identification (Please print…*Imprima por favor*)

Patient's Name (Nombre Apellido) ____
First *Middle* *Last*

Date of Birth (Fecha de nacimiento) ______________________ ☐ Female ☐ Male Race______________

Street Address (Dirección Calle) ____

City (Ciudad) ______________________________ State __________ Zip (Postal codigo) ___________________

Phone (teléfono): Home/Casa _________________________ Cell/Cellular ______________________________

Email (Correo electrónico) ____

Emergency Contact *(Contact de Emergencia*)

Name (Nombre) ____

Relationship to patient (relacion con el paciente) ____

Address (Dirección) ____

City (Ciudad) ____________________________ State _________ Zip (Postal codigo) ______________________

Phone (teléfono): Home/Casa _________________________ Cell/Cellular ______________________________

Email (Correo electrónico) ____

Who Should Correspondence be Sent To? *(¿Que correspondencia deberán dirigirse?)*

Name (Nombre) ____

Relationship to patient (relacion con el paciente) ____

Address (Dirección) ____

City (Ciudad) ____________________________ State _________ Zip (Postal codigo) ______________________

Phone (teléfono): Home/Casa _________________________ Cell/Cellular ______________________________

Email (Correo electrónico) ____

It is very important to keep your appointments. Please notify us **24 hours prior to your appointment** if you will not be able to keep the appointment. **Otherwise, it will be counted as cancelled and after three cancelled appointments, we will not be able to serve you at Truth's Community Clinic**. *Es muy importante mantener sus citas. Por favor notifíquenos 24 horas antes de su cita si no podrá asistir a la cita. De lo contrario, se contarán como cancelada y después tres anulación de citas, no podremos atenderle en la clínica de comunidad de verdad.*

Signature (Firma) ____ Date (Fecha) ____________________

Truth's Community Clinic
PRIVACY POLICY FOR TCC

Truth's Community Clinic (TCC) has in place privacy policies to protect the confidentiality of patient information in accordance with the patient's wishes and state and federal laws. The passage of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that these policies and procedures be made available to patients in the form a "Privacy Policy". The following policy statement is provided to the patients of TCC in compliance with the requirements of the HIPAA and resulting regulations. This policy states how your medical information, referred to as "protected health information (PHI)" may be used and disclosed and how you may access that information. PLEASE READ CAREFULLY.

TCC will not use or disclose your PHI without your written authorization except as described in this policy. TCC reserves the right to change its practices and this policy and to make the new policy effective for all PHI that we maintain. Upon request we will provide revisions to you.

The patient may authorize the use of patient's PHI in any way the patient so desires by submitting a request to TCC in writing. TCC will comply with the patient's instructions within the parameters of State and Federal laws. TCC is not required to agree to restrictions on the use of PHI that would interfere with treatment and quality of care.

1. TCC may discuss PHI with the patient's other health care providers, as provided by law, to the extent that such communications pertain to the treatment and quality of care for that patient. TCC may also disclose to the FDA, or its representatives PHI relative to adverse events with respect to pharmaceuticals or other products to facilitate product recalls, repairs or replacements.
2. Current Georgia Law requires the release of PHI on a court order or subpoena. TCC may also release PHI to comply with Georgia Workers Compensation Laws, to meet requirements of Public Health Laws and to comply with requirements of law relating audits, investigations and inspections necessary for TCC and for the government to monitor the health care system, government programs and compliance with civil rights laws.
3. TCC will make available to the patient copies of the patient's PHI upon request. If you feel that your PHI is incomplete or incorrect you may request that it be amended. Such requests must include the reason for the request and must be in writing to TCC. Your request may be denied. If denied you have the right to file a statement of disagreement and TCC may give a rebuttal to your statement of disagreement.
4. TCC will counsel the patient on proper use of medications, possible reactions, interactions and side effects of medication and will answer any questions from the patient on prescribed medications as provided by law. Such counseling may be by telephone, within the area of the pharmacy department or other mutually agreeable area unless directed to not do so by the patient.
5. TCC may leave voice messages or mail reminders to the patient regarding necessary refills or compliance with medication therapy for the improvement of the patient's health care.
6. TCC will allow the patient's representative to pick up and deliver to the patient prescription medications and other health care needs unless instructed not to do so by the patient. The personal representative can be anyone so designated by the patient. In the case of a minor child, this personal representative may be designated by the parent, guardian or other legally qualified person.
7. TCC will not authorize the use of PHI by any person or entity for the purposes of contacting patient for marketing unless specifically authorized by the patient.
8. For the purposes of providing quality health care and services TCC personnel will have access to certain PHI. All such personnel have received training in the confidentiality of PHI.
9. Patients who feel that their privacy rights have been violated are requested to contact TCC in writing c/o Hebron Baptist Church at PO Box 279 Dacula, GA 30019 to obtain information on the submission of a complaint.
10. All patients will be afforded opportunity to review this policy and a copy will be made available to any patient upon request. Patient will be asked to sign an acknowledgement of notice of this Privacy Policy as required by HIPAA.
11. All documentation on patient will be retained by TCC in accordance with Federal and State Laws. When such documentation is to be destroyed, procedures are utilized that insure the security of that information. The effective date of this Privacy Notice is 11/4/2003.

I have read and fully understand this Privacy Policy.

________________________________ Name

__________________________ Date

Truth's Community Clinic • Patient Health/Medication History

250 Langley Drive, Ste. 1316 • Lawrenceville, GA 30046 • 770-277-4675 FAX 770-277-1575

Please Print (Imprima por favor)

Patient Name:		
	LAST Name/*Apellido* FIRST/*Nombre*	DOB/*Fecha de nacimiento*

HEALTH HISTORY:

Check ALL that apply…*Marque todo lo que corresponda*

AIDS/HIV, *sida* ☐
Anemia ☐
Arthritis, Rheumatism *artritis, reumatismo* ☐
Artificial heart valves *valvulas artificiales delcorazón* ☐
Artificial joints *ligamentos artificiales* ☐
Asthma, *asma* ☐
Back, *espalda* ☐
Bleeding, *hemorragia* ☐
Bleeding gums, *hemo.de encias* ☐
Blisters on lips or mouth *bolsas en los labios o boca* ☐
Blood disease, *sangre* ☐
Burning sensation on tongue *sensacion de guemason/lengua* ☐
Cancer, *cáncer* ☐
Chemical Dependency *químico dependencia* ☐
Chemotherapy, *quimioterapia* ☐
Chew on one side of mouth *mastica con un lado de la boca* ☐
Cigarette, pipe, cigar smoking *fuma cigarillos, cigaros, pipa* ☐
Circulation ☐
Clicking/popping jaw *quijada se traba o hace click* ☐

Cortisone ☐
Coughs, *tos* ☐
Diabetes ☐
Dry mouth *boca seca* ☐
Emphysema, *enfisema* ☐
Epilepsy, *epilepsia* ☐
Fainting/dizziness, *desmayo, mareado* ☐
Fingernail biting *se muerde las unas* ☐
Glaucoma ☐
Grinding teeth *muele o rechina los dientes* ☐
Gums swollen/tender *encias inflama das* ☐
Headaches, *dolor de cabeza* ☐
Heart surgery, *corazón* ☐
Heart murmur, *palpicaciones* ☐
Hepatitis type____ ☐
Herpes ☐
High/low blood pressure, *alta o baja presión* ☐
Jaw, *mandibula* ☐
Kidneys, *riñon* ☐
Liver, *hígado* ☐
Mouth breathing *respira por la boca* ☐

Mouth pain, brushing *dolor de boca cuando se cepilla* ☐
Nerves, *nervios* ☐
Orthodontic treatment *tratamiento ortoneista* ☐
Pacemaker, *marcarpasos* ☐
Pain around ear *dolor alrededor de oido* ☐
Periodontal treatment *tratamiento perodontal* ☐
Radiation, *radiación* ☐
Respiratory, *respiratorio* ☐
Rheumatic fever, *fiebre reumática* ☐
Scarlet fever, *escarlatina* ☐
Sensitivity to/*sencitividad a:* cold-*frio*,heat-*calor*,sweet-*dulce* ☐
Shortness of breath *falta de aliento* ☐
Stroke, *derrame de cerebral* ☐
Swollen feet/ankles, *hinchado* ☐
Thyroid, *tiroides* ☐
Tonsillitis, *amigdalitis* ☐
Tuberculosis ☐
Tumor/growth ☐
Ulcer, *úlcera* ☐
Venereal disease, *venéreo* ☐
OTHER: ☐

For women, *mujeres*:

Pregnant/trying to be *embarazado o tratando* ☐
Nursing *lactando* ☐
Taking oral contraceptives *anticonceptivos orales* ☐

MEDICATIONS (*MEDICAMENTOS)*:

Medications you're taking & correlating diagnosis ____________________
Está Ud. Tomandano edicamentos, pildoras o drogas – quales ____________________

Circle if allergic to: aspirin, penicillin, codeine, sulfur, latex, other: ____________________
Circule si tiene allergias a: aspirina, penicilina, codina, sulfa, helle, otro: ____________________

Do you need antibiotics before dental procedures? *(Necesita antibiótico antes tratamiento?)* ____________________

Receive medications free *(Recibe usted reciben ustedes algun medicamento gratin)?* Yes (sí) No

Receive any medications by paying only a part of the total price? Yes (sí) No
Recibe usted algun medicamentos pagando solamente una porcion del precio? Yes (sí) No

Do you need a translator to speak to the doctor/dentist? Yes (sí) No

Patient's signature/Firma de paciente ____________________ Date/Fecha ____________________