Patient Name:____________________ DOB: _________________________

FIRST POINT URGENT CARE INC.

2-17 Years Old Immigration Screening Form

First Name: ____________________________ **Middle Name:** _____________ **Last name:** _______________________

Date of Birth: ___________________________

Place of Birth (City/Town/Village): ____

Country of Birth: ____

Current U.S. Address: ____

City: _________________________________ **State:**_____________________ **Zip Code:** ________________________

Alien Registration Number A-_______________________________________

Race: ☐ Asian ☐ Black ☐ White ☐ Other

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Prefer not to disclose Other

<u>Caregiver completing this form</u>:

Relationship to patient: ____

First Name: _____________________________**Middle Name:** _____________ **Last Name:** ______________________

Current U.S. Address: ____

City: ____ **State:**____________ **Zip:** ___________________________

Cell Phone Number: _________________________________ **Home Phone Number:** ______________________________

Work Phone Number: ________________________________ **Email Address:** __________________________________

Patient Name:____________________ DOB: _________________________

I authorize First Point Urgent Care to correspond with me with email that is NOT encrypted and not HIPAA Compliant (circle one) True False

Please initial below:

________ I have been given the opportunity to read the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_________ I have read, understand, and agree to the Payment Policy outlined by First Point Urgent Care (FPUC).

Sharing of Medical Information.

****Note: If the following information is left blank, we cannot share medical information with any person.*

I authorize First Point Urgent Care to discuss my child's medical health information with:

First Name: _______________________________________ Last Name: __________________________________

Date of birth: ______________________________________ Relationship: ________________________________

Is there a chance the patient might be pregnant?*

___She is pregnant
___She is not pregnant
___I am unsure if she is pregnant
___Not applicable

Patient Name:____________________ DOB: _________________________

Past Medical History (required):

History of tuberculosis vaccine: **Yes** ☐ **No** ☐

History of latent tuberculosis: **Yes** ☐ **No** ☐

History of tuberculosis treatment: **Yes** ☐ **No** ☐

History of positive tuberculosis skin test: **Yes** ☐ **No** ☐

History of syphilis: **Yes** ☐ **No** ☐

History of gonorrhea: **Yes** ☐ **No** ☐

History of substance abuse: **Yes** ☐ **No** ☐

History of behavioral health medication: **Yes** ☐ **No** ☐

History of behavioral health admission: **Yes** ☐ **No** ☐

History of behavioral health counseling: **Yes** ☐ **No** ☐

History of Hansen's (skin) disease: **Yes** ☐ **No** ☐

History of Leprosy: **Yes** ☐ **No** ☐

If "yes" to any health history questions above, please provide date(s):

____

____

____

Surgical History (Type of Surgery/Reason and Year):

____

____

____

Medication Allergies (Name of Medication/Product and Reaction):

____

____

____

Medications/Supplements (Name, Strength and Frequency):

____

____

____

____

Other Providers you see (Name, Phone# and Specialty):

____

____

____

____

Current Primary Care Physician (Name and Phone#):

____

Signature: ____

Printed Name: ____

Today's Date: ________________________________

Patient Name:_____________________ DOB: ___________________________

Caregiver to answer the following questions.

Please mark under the option that best fits your child.

Fidgety, unable to sit still:
_____Never
_____Sometimes
_____Often

Feels sad, unhappy:
_____Never
_____Sometimes
_____Often

Daydreams too much:
_____Never
_____Sometimes
_____Often

Refuses to share:
_____Never
_____Sometimes
_____Often

Does not understand other people's feelings:
_____Never
_____Sometimes
_____Often

Feels hopeless:
_____Never
_____Sometimes
_____Often

Has trouble concentrating:
_____Never
_____Sometimes
_____Often

Is down on him or herself:
_____Never
_____Sometimes
_____Often

Fights with other children:
_____Never
_____Sometimes
_____Often

Patient Name:_____________________ DOB: ___________________________

Blames others for his or her troubles:
_____Never
_____Sometimes
_____Often

Seems to be having less fun:
_____Never
_____Sometimes
_____Often

Does not listen to rules:
_____Never
_____Sometimes
_____Often

Acts as if driven by a motor:
_____Never
_____Sometimes
_____Often

Teases others:
_____Never
_____Sometimes
_____Often

Worries a lot:
_____Never
_____Sometimes
_____Often

Takes things that do not belong to him or her:
_____Never
_____Sometimes
_____Often

Distracted Easily:
_____Never
_____Sometimes
_____Often

Signature: ____

Today's Date: ____