ENGLISH

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

REGISTRATION FORM/FORMULARIO DE REGISTRACION

Date/*Fecha*: ____________________ **Chart No./*No de Expediente*:** ____________________

PATIENT INFORMATION/*INFORMACION DEL PACIENTE*

1. Last Name/*Apellido* First/*Primer Nombre* Name You Go By/Nombre Preferido | 2. Mother's Maiden Name/*Apellido Materno*

3. Sex/*Sexo* ☐ M ☐ F | 4. Social Security/*Seguro Social* | 5. Birthdate/*Fecha de Nacimiento* | 6. Age/*Edad*

7. Address/*Dirección* Street/*Calle* City/*Ciudad* Zip Code/*Código Postal*

8. Home Phone/*Teléfono*:

9. Cell Phone/*Numero de Celular*

10. Email Address/*Correo Electrónico*:

11. Preferred Method of Contact?/*¿Método de contacto preferido?*
☐ Call on Phone/*Llamada por teléfono* ☐ Text/*Texto* ☐ Email/*Correo electrónico*

If none of these, how can we reach you?/*Si ninguno de estos,¿cómo podemos comunicarnos con usted?*

- By answering, you are giving your consent which allows us to contact you via phone calls, texting or emails./
- *Contestando, usted esta dando su consentimiento el cual nos permite contactarlo por medio de llamadas telefónicas, mensajes de texto o correo electrónico.*

12. Emergency Contact/*Contacto de Emergencia*:
Name/*Nombre*: ____________________
Telephone No./*Teléfono*: ____________________
Relationship/*Relación*: ____________________

13. Primary Language/*Idioma Principal*:
☐ English/*Ingles*
☐ Spanish/*Espanol*
☐ Other/*Otro*: ____________________

14. Is this your permanent residence?/ *¿Es este su domicilio permanente?* ☐Yes/*Si* ☐ No
(If NO, answer questions a, b, and c/*Si NO, responda preguntas a, b, c.*)
a. Are you homeless?/*¿Vive usted sin hogar?* ☐Yes/*Si* ☐ No
b. Are you living with family or friends?/ *¿Esta viviendo con familia o amigos?* ☐Yes/*Si* ☐ No
c. Do you live in a shelter, transitional housing?/ *¿Vive en un refugio o casa transicional?* ☐Yes/*Si* ☐ No

15. Are you a Migrant Worker?/*¿Es usted un trabajador agricola?* ☐Yes/*Si* ☐ No

16. Interpreter services needed?/ *¿Necesita servicios de interpretación?* ☐Yes/*Si* ☐ No

17. Are you a Veteran?/*¿Es Usted un Veterano?* ☐Yes/*Si* ☐ No

18a. Race/*Raza*: **Please select all that apply/*Por favor seleccione todo lo que aplique***
☐ White/*Blanco* ☐ Asian/*Asiática* ☐ Native Hawaiian or other Pacific Islander/*Nativo de Hawai o las Isles del Pacifico*
☐ Black/*Afro-Americano* ☐ American Indian or Alaskan Native/*Nativo Americano o de Alaska* ☐ Decline to State/*Rehusó a contestar*

18b. Ethnicity/*Pertenecia Étnica*:
I am of Hispanic or Latino origin/*Soy de origen hispano o latino* ☐Yes/*Si* ☐ No

Hispanic or Latino (All Races): A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
Hispano o Latino: Persona Cubana, Mexicana, Puertorriqueño, Sur y America Central, o de otro originen latino, a pesar de raza.

I am *not* of Hispanic or Latino origin/*No soy de origen hispano o latino* ☐Yes/*Si* ☐ No

Not Hispanic or Latino (All Races): A person *not* of Cuban, Mexican, Puerto Rican South or Central American, or other Spanish culture or origin, regardless of race.
Hispano o Latino: Persona no Cubana, Mexicana, Puertorriqueño, Sur y America Central, o de otra culture u origen latino, a pesar de raza.

19. Marital Status/*Estado Civil*:
☐ Single/*Soltero/a* ☐ Married/*Casado/a*
☐ Divorced/*Divorciado/a* ☐ Widowed/*Viudo/a*
☐ *Life Partner/Pareja de Vida*
☐ *Separated/Separado(a)*
☐ *Other/Otro* ____________________

21. Do you have?/*Usted tiene?*:

Medi-Cal	☐Yes/*Si* ☐ No	Policy No./*No de Póliza*:
Healthy San Francisco	☐Yes/*Si* ☐ No	Policy No./*No de Póliza*:
Medicare	☐Yes/*Si* ☐ No	Policy No./*No de Póliza*:
Other Insurance/Otro Seguro	☐Yes/*Si* ☐ No	Policy No./*No de Póliza*:

FINANCIAL /INSURANCE INFORMATION/*INFORMACION DE SUS INGRESOS Y SEGURO MEDICO*

22. Family Size?/*¿Cuentos en la familia?*

23. Family's Monthly Income/Ingresos Mensuales:

24. Responsible Party's Employer/*Trabajo de la Persona Responsable*:

25. Address and Phone No. of Employer/*Dirección y Teléfono de su Trabajo*:

____________________ **Entered By:** ____________________
(Staff Initials)

Patient/Parent or Guardian Name (please print) /
Nombre de Padre o Guardián (por favor escriba su nombre)

T-HI0001 STUDENT →

NAME
DOB
MRN
PCP
Patient ID / Addressograph

San Francisco Department of Public Health

SFDPH Summary Notice of HIPAA Privacy Practices and Acknowledgement of Receipt

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: https://www.sfdph.org/dph/comupg/oservices/medSvs/HIPAA/HIPAASummaries.asp.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates, as well as staff assigned to DPH by the University of California at San Francisco, must follow these rules.

You have the right to: (Please see possible restrictions in the "Full Notice of Privacy Practices".)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask that copies of your health record be sent to someone (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how DPH employees may contact you.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, health information may be shared between treatment providers, including your health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as services received in substance abuse treatment agencies.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) Secretary of U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94103. (2) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 330, San Francisco, CA 94102, or call toll-free 1-855-729-6040. You will not be penalized in any way for filing a complaint.

PARENT / GUARDIAN

I acknowledge receipt of the SF Department of Public Health "Full Notice of HIPAA Privacy Practices."

SIGNATURE OF PATIENT/RESIDENT/CLIENT OR THEIR REPRESENTATIVE *		DATE *
PRINT NAME *	IF REPRESENTATIVE, SPECIFY RELATIONSHIP	INTERPRETER IF APPLICABLE

STAFF/WITNESS: If written acknowledgement is NOT obtained, please complete the following:

☐ Unable to sign ☐ Declined to sign ☐ Other, Describe:

SIGNATURE OF STAFF WITNESS	DATE
PRINT NAME	DEPARTMENT/ORG

STUDENT

San Francisco
Health Network
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

NAME

DOB

MRN

PCP

Patient ID / Addressograph

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

PARENT / GUARDIAN

CERTIFICATION

I hereby certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise duly authorized by the patient to sign the above and accept its terms on his/her behalf.

*Date: ______________ *Time: ______________ AM/PM

*Signature: ______________________________
Patient or Legal Representative

*Print Name: ______________________________ Cell #( ) -
Patient or Legal Representative

☐ Refused to Sign ☐ Physically Unable to Sign

If signed by someone other than the patient, indicate
*relationship: ______________ and Date of Birth ______________

Witness: ______________ ______________ ______________
Signature Print Name and Title Date/Time

Witness: ______________ ______________ ______________
Signature Print Name and Title Date/Time

Interpreter: ______________ ______________ ______________
Signature Print Name Date/Time

San Francisco
Health Network
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

T-AD0014

NAME
DOB
MRN
PCP
Patient ID / Addressograph

TERMS AND CONDITIONS OF ADMISSION FOR ACUTE INPATIENT, OUTPATIENT AND EMERGENCY SERVICES

I. GENERAL CONSENT

A. Consent to Medical and Surgical Procedures: I consent to the procedures which may be performed during this hospitalization or while I'm an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instruction of a physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment. Maternity Patients: If I deliver an infant(s) while a patient of this hospital, I agree that these same conditions of admission apply to the infant(s).

B. Photography/Videotaping: I consent to the taking of pictures, videotapes and recordings necessary for identification purposes, to document processes of diagnosis and treatment and to document injuries sustained in trauma. I further consent to the use of such pictures, videotapes and recordings for provision of care, quality improvement, education, and reimbursement purposes.

C. Teaching, Research and Healthcare Institution: Zuckerberg San Francisco General Hospital, Laguna Honda Hospital and affiliated clinics are a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the medical education programs. I also understand that an institutional review board approves projects conducted by the researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

D. Use of Medical Information and Specimens: I understand that my medical information, photographs, and/or video in any form may be used for other Department of Public Health (DPH) purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that the DPH may collect during the course of my treatment and care may be used and shared with researchers and any such use will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the Notice of Privacy Practice. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research.

English

San Francisco Health Network
Primary Care

Label

Behavioral Health Vital Signs

Life gets more complex as you get older. On top of all of the emotional and physical changes you go through, there are more choices and decisions to make and more stresses from school, sports, jobs, family, and even friends.
So who can you talk to about your physical and emotional concerns? Sometimes friends or parents can be helpful, but you can always talk to your primary care provider too.

To help start the conversation with your provider, we have some questions we would like to ask to get a sense of how you have been doing and feeling lately.

PHQ-A

In the last **TWO WEEKS,** have you been bothered by:	Not at all	Several Day	More than half the days	Nearly Every Day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3
i. Has there been a time in the **past month** when you have had serious thoughts about ending your life?	Yes	No	Skip	
ii. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt?	Yes	No	Skip	

CRAFFT Screening

During the last 12 months did you:		
3. Drink more than a few sips of beer, wine, or any drink containing alcohol?	No	Yes
4. Use any marijuana (weed, oil, or hash by smoking, vaping, or in food)?	No	Yes
5. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff or vape)?	No	Yes
6. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	No	Yes

BHVS IPV

7. Has your partner, ex-partner, or someone close to you often screamed or cursed at you, insulted you, or put you down?	Yes , in the past 12 months	Yes, more than a year ago	No	Skip
8. Has your partner or anyone else hurt, hit, threatened you or made you feel afraid?	Yes , in the past 12 months	Yes, more than a year ago	No	Skip