REGISTRATION - PLEASE PRINT ALL INFORMATION IN THIS BOX AND SIGN BELOW

PATIENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH
EMPLOYER OR SCHOOL	SOCIAL SECURITY NUMBER	SEX ( ) M ( ) F	MARITAL STATUS ( ) M ( ) S
MAILING ADDRESS	CITY	STATE	ZIP CODE
PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	

Which phone number is the best way to contact you? □ Home □ Cell □ Work □ Other _____
Is it okay to leave a message? □ yes □ no
Is it okay to send statements, if needed? □ yes □ no

EMERGENCY CONTACT (18 or older)	RELATIONSHIP	PHONE

Ethnicity (Select one)	Race (Select one)
□ Hispanic □ Non-Hispanic	□ White □ Black □ Native American/Alaska Native □ Asian □ Pacific Islander What language do you speak at home? _____

I hereby acknowledge that I am aware of Carson City Health & Human Services Notice of Privacy Practices. Copies are available for review in the waiting room or upon request. All records of minors will be kept for a minimum of 5 years after that individual turns 18 (NRS 626.06)

PATIENT SIGNATURE_____ **DATE** _____

□ SPOUSE □ PARENT □ GUARDIAN □ INSURANCE POLICY HOLDER INFORMATION

SPOUSE/PARENT LAST NAME	FIRST NAME	INITIAL	**RELATIONSHIP TO PATIENT
SOCIAL SECURITY NUMBER	WORK PHONE /CELL PHONE	DATE OF BIRTH	SEX ( ) M ( ) F
MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

INSURED PATIENTS ONLY

A copy of your insurance card (s) & Driver's license are required at the time of registration.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to The Carson City Community Health Clinic Physician for Medical Benefits. I hereby authorize The Carson City Community Health Clinic to release any information necessary to process this claim.

SIGNED_____ DATE _____

If form not signed by the patient, please indicate relationship:
□ Parent or Guardian of minor patient, please indicate relationship _____
□ Guardian or conservator of an incompetent patient
□ Beneficiary or representative of deceased patient
□ Other (specify) _____

Carson City Health & Human Services
Carson City Community Health Clinic
900 E. Long St. Carson City, NV 89706
Tel. 887-2195 Fax 887-2192

Douglas County Community Health
1538 Hwy 395.N. Gardnerville, NV 89410-5207
Tel. 782-9038 Fax 782-9875

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

Your health care here is voluntary and confidential. No information will be given out about you without your written permission except as required by law or to provide services to you in compliance with federal privacy and security standards.

Please Note:

1. **We are mandatory reporters of Statutory Sexual Seduction (N.R.S. 432B.220).** This means that if you are 15 years of age or younger and are having sex with someone 18 years of age or older and you tell us, we must report it to law enforcement.
2. **We are also mandatory reporters of Child Abuse and Neglect (N.R.S. 432B.220).** This means that if we have cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.
3. **We are also mandatory reporters of lewdness (sex) with a child under the age of 14 (NRS 201.230).** This means that if we have a cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.
4. **We are required to report (NAC 441A.230) certain communicable diseases, such as:** Chlamydia, Gonorrhea, Syphilis, HIV/AIDS and Hepatitis. If you have a positive test result for certain communicable disease we are required to report the results. In some cases, you may be contacted by a clinic investigator who will ask you to provide information about your contacts in order to provide them with testing and treatment.

In this clinic you can choose your method of birth control (as long as it will not cause you health problems). You can also refuse any method of birth control or other services offered by this clinic.

I have the right to know everything about my care and I am encouraged to ask questions.

I understand that in order for us to provide the services I request, I may need to have an examination and/or lab tests, and treatment may be recommended. These may include:

Physical examination	**Lab tests**	**Treatment**
Weight & blood pressure check	Urine	Oral & topical treatment of minor gynecological
Exam of head, neck, lungs, heart,	Vaginal fluids	Health & skin conditions
breasts, abdomen, pelvis, rectum,	Blood tests	Certain communicable diseases,
arms & legs	Pap tests	including STD's

I have read (or have had read to me) the above information, understand this information, and give my permission for examination, treatment, and care by the staff of the Carson City Community Health Clinic.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Family Planning only: I have voluntarily chosen to receive health care at the Carson City Community Health Clinic. I have not been coerced into receiving services or to use any particular method of birth control. I understand that acceptance of family planning services is not necessary in order for me to participate in other programs or to receive other services offered by the Carson City Community Health Clinic.

HIV rapid testing will be part of your exam today. Please let your provider know if you wish **NOT** to have this test done.

Family Planning - <18 years of age: (please mark the appropriate box)

□ I would like my parents to be involved in my Family Planning Decision.
□ Do not contact my parents.
□ I need help in telling my parents.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Carson City Health & Human Services
Carson City Community Health Clinic
900 E. Long St. Carson City, NV 89706
Tel. 887-2195 Fax 887-2192

Douglas County Community Health
1538 Hwy 395.N. Gardnerville, NV 89410-5207
Tel. 782-9038 Fax 782-9875