



**COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
REGISTRATION FORM**



PATIENT INFORMATION								
Last Name:		First Name:		MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /	Social Security Number:	
Mailing Address:				City, State:		Zip Code:	County:	
Home Phone: ()		Cell Phone: ()		Email Address:				
Race (Circle One) White/ Black or African American/ American Indian or Alaska Native/ Asian/ Hawaiian or Pacific Islander/ Multi-racial/ Other:						Ethnicity: Hispanic or Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:				Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Primary Care Physician:				Primary Dental Provider:				

GUARANTOR INFORMATION					
Name of Responsible Party:		Birth date: / /	Relationship of Responsible Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Caregiver <input type="checkbox"/> Other:		
Address (if different than patient):			City, State:		Zip Code:
Home Phone: ()		Cell Phone: ()		Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	

INSURANCE INFORMATION				
(Please provide complete insurance information regardless of type of service utilizing. Provide all cards to the front desk.)				
Primary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:				
Subscriber Name:		Date of Birth: / /	Policy/ID Number:	
Secondary <u>Medical</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:				
Subscriber Name:		Date of Birth: / /	Policy/ID Number:	
Primary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:				
Subscriber Name:		Date of Birth: / /	Policy/ID Number:	
Secondary <u>Dental</u> Insurance: <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private/Commercial:				
Subscriber Name:		Date of Birth: / /	Policy/ID Number:	

ANNUAL INCOME					
Please circle next to your family size what income range best fits your household.					
Family Size					
1	\$0 - \$12060	\$12061 - \$18090	\$18091 - \$21105	\$21106 - \$24120	\$24121 and up
2	\$0 - \$16240	\$16241 - \$24360	\$24361 - \$28420	\$28421 - \$32480	\$32481 and up
3	\$0 - \$20420	\$20421 - \$30630	\$30631 - \$35735	\$35736 - \$40840	\$40841 and up
4	\$0 - \$24600	\$24601 - \$36900	\$36901 - \$43050	\$43051 - \$49200	\$49201 and up
5	\$0 - \$28780	\$28781 - \$43170	\$43171 - \$50365	\$50366 - \$57560	\$57561 and up
6	\$0 - \$32960	\$32961 - \$49440	\$49441 - \$57680	\$57681 - \$65920	\$65921 and up
7	\$0 - \$37140	\$37141 - \$55710	\$55711 - \$64995	\$64996 - \$74280	\$74281 and up
8	\$0 - \$41320	\$41321 - \$61980	\$61981 - \$72310	\$72311 - \$82640	\$82641 and up

EMERGENCY CONTACT				
Name of local friend or relative:		Relationship to Patient:	Home Phone: ()	Cell Phone: ()

By signing below I agree that the above information is accurate and true to the best of my knowledge:	
Patient/Guardian Signature:	Date:



GENERAL POLICIES AND CONSENT

APPOINTMENT TIMES

All **new patients** are required to check in at least 30 minutes prior to their appointment. This allows the patient time to complete the required paperwork and allows the staff to have the patient in the exam room by the appointment time.

All **established patients** must check in at least 15 minutes prior to their appointment. This will allow the patient time to update any necessary paperwork and allows the staff to get the patient in the exam room by the actual appointment time. This will allow for a much smoother and timely visit.

You will receive a phone call reminding you of your appointment time two days prior to your scheduled visit. It is important you provide a working telephone number and inform us of any changes so we are able to remind you of your visit.

Any patient who does not check in by the times listed above will need to be rescheduled.

All minors (children aged 17 and under) must be accompanied by a parent or legal guardian at all appointments.

FINANCIAL AGREEMENT

Payment is expected at time of service. If payment is not made at time of appointment patient will be rescheduled to a time agreed upon that they will be able to pay for services to be rendered.

If insurance has been provided, you are hereby authorizing CHCCMO to release health information necessary to process your claims. In addition you are also authorizing payment for insurance benefits to be paid directly to CHCCMO. You understand that you are responsible for any copays, coinsurance, deductibles, or non-covered services.

CONSENT TO TREAT

By signing below I consent to receiving care considered advisable from a CHCCMO provider. Such treatment may include, but is not limited to, examination and basic diagnostic testing. I attest that I have the legal authority to make health care decisions and act on behalf of the patient if the patient is a minor or otherwise incapacitated.

PERSONAL VALUABLES

I recognize that CHCCMO is not responsible for any personal property brought onto CHCCMO's premises.

MISSED APPOINTMENTS

The Community Health Center of Central Missouri is dedicated to serving the members of our community. Our missed appointment policy is strictly enforced as we truly desire to provide timely, quality care to our patients, but this becomes difficult when patients miss scheduled appointments.

You will be notified of a missed appointment in one of the following methods; phone call or a letter.

We value family here and understand that it is often easiest to schedule all appointments on the same day. If you miss appointments scheduled for multiple family members, each family member will only be given appointments on different days in the future. If a child is requiring treatment, it is important to keep these appointments so they can receive necessary care. Failure to bring a child for treatment is considered neglect. CHCCMO is required to report suspected cases of neglect.

Continued on next page...

MISSED APPOINTMENTS CONTINUED...

FAMILY PRACTICE/PEDIATRICS/OB/GYN/MENTAL HEALTH

You will be allowed 3 no shows (failure to present to clinic) for the above appointment types at which time you will not be allowed to schedule an appointment for a period of 1 year. You will still be granted care on an emergent basis as a walk-in only without guarantee of being seen the day you come in.

DENTAL

For dental appointments, a missed appointment is defined as follows:

1. Any appointment for which the patient does not present to the designated clinic/location
2. Any appointment cancelled with less than 24 hours' notice
3. Showing up for an appointment 10 or more minutes late, necessitating the appointment be rescheduled
4. Showing up without appropriate payment that was previously quoted resulting in appointment needing rescheduled
5. Minor who shows up without accompanying adult specified on recent patient paperwork

After your initial missed appointment, any future appointments will be cancelled and rescheduled one at a time. Any patient who accumulates 2 missed appointments within a 6 month period will not be allowed to schedule an appointment for a period of 6 months. During that time that patient can seek care via "same day appointments" only; you will need to call the office the day you wish to seek care to see if any openings are available so that we can assist you.

If a patient is reinstated to be seen after their 6 month period or scheduled for a same day visit and accumulates another missed appointment, they will then be unable to schedule an appointment for 1 year and be seen only for emergent dental needs under our limited program.

I have read and fully understand the policies and consents included on this form.

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE

DATE



Health Information Exchange Opt In

Printed Name: _____ Date of Birth: _____
Street Address: _____ City: _____
State: _____ Zip: _____ Phone: _____

I hereby authorize Community Health Center of Central Missouri to RELEASE and OBTAIN all of my medical records and medical information, including records which relate to any physical or mental condition, psychological condition, psychiatric evaluation and treatment, psychotherapy, counseling, drug addiction, infection status, HIV/AIDs, genetic testing, or treatment for drug or alcohol abuse, even though such information is protected by federal law, to and from the following HIEs:

- Tiger Institute Health Information Alliance
- Carequality/SureScripts

The purpose of this disclosure is for healthcare treatment purposes, change in providers and continuity of healthcare. I specifically authorize the release of my medical information to and from the above HIEs in an electronic format.

ACKNOWLEDGEMENT OF UNDERSTANDING:

-I understand that the HIE allows multiple healthcare provider to link by electronic medical records. When I go to an outside healthcare provider, Community Health Center of Central Missouri may be able to share and/or obtain my medical records through the HIE. All providers must have sufficient personal information about me to prove they have a treatment relationship with me before the HIE will allow access to my information.

This authorization will remain in place until revoked by me. I understand that I may revoke this authorization at any time by notifying the Community Health Center of Central Missouri in writing, and it will be effective on the date received. However, it will not have any effect on actions already taken by my healthcare providers in reliance on this written authorization to release my medical information.

Signature of Patient and/or Legal Guardian: _____

Relationship to Patient: _____ Date: _____

Witnessed By: _____ Date: _____

Patient Name: _____ DOB: _____

PATIENT HISTORY

Medications

Preferred Pharmacy: _____

List any current medications (including over the counter, vitamins, and birth control)

Are you currently being treated by another provider with any of these medications? Yes No

If yes, please list the provider(s): _____

Allergies

No Known Allergies

List any allergies and the allergic reaction.

Medical History

Place a checkmark next to any of the below conditions you have a history of and indicate the year diagnosed if known.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Gallbladder Disease _____ | <input type="checkbox"/> Seizure Disorder _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Acid Reflux _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Headache, migraine _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Benign Prostatic Hypertrophy _____ | <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Clots _____ | <input type="checkbox"/> Hepatitis/liver disease _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Irritable Bowel Disease _____ | |
| <input type="checkbox"/> Depression _____ | | |

Surgical History

Place a checkmark by any surgery you have had and the year performed.

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Stent _____ | <input type="checkbox"/> Gallbladder Removed _____ | <input type="checkbox"/> Joint Surgery (ORIF) _____ |
| <input type="checkbox"/> Appendix Removed _____ | <input type="checkbox"/> Colon Removed _____ | <input type="checkbox"/> Thyroidectomy _____ |
| <input type="checkbox"/> Arthroscopy _____ | <input type="checkbox"/> Colon Surgery _____ | <input type="checkbox"/> Tonsillectomy _____ |
| <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Gastric Bypass _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Blood Transfusion _____ | <input type="checkbox"/> Hernia Repair _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart Bypass _____ | <input type="checkbox"/> Hip Replacement _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac Pacemaker _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Carpal Tunnel Release _____ | <input type="checkbox"/> Knee Replacement _____ | |
| <input type="checkbox"/> Cataract Extraction _____ | <input type="checkbox"/> LASIK _____ | |

Continued on next page....

Patient Name: _____ DOB: _____

Family

Father Alive and Well Deceased – Cause? _____

Mother Alive and Well Deceased - Cause? _____

Has any blood relative ever had? (Check and list who)

- | | |
|--|--|
| <input type="checkbox"/> ADD/ADHD _____ | <input type="checkbox"/> Hearing Deficiency _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Heart Trouble _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> Irritable Bowel Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Learning Disability _____ |
| <input type="checkbox"/> Blood Disorder _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Migraines _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Obesity _____ |
| <input type="checkbox"/> Developmental Delay _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Eczema _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Genetic Disease _____ | <input type="checkbox"/> Thyroid Disorder _____ |

Diagnostic/Screening Studies

If you have had any of the following performed, indicate the most recent date/year performed and where performed.

- | | |
|--|--|
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Colonoscopy _____ |
| <input type="checkbox"/> Pap Smear _____ | <input type="checkbox"/> Other: _____ |

Females Only: Last Menstrual Period __/__/__

Social

Tobacco Use (Check One) Ex-Smoker Never Used Current Use

Indicate form of tobacco and how often used i.e. daily, occasional (skip if not a current user)

- | | |
|---|--|
| <input type="checkbox"/> Cigarettes _____ How many packs per day? _____ | <input type="checkbox"/> Chewing _____ |
| <input type="checkbox"/> Cigarette _____ | <input type="checkbox"/> Smokeless _____ |
| <input type="checkbox"/> Cigar _____ | <input type="checkbox"/> Snuff _____ |
| <input type="checkbox"/> Pipe _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Electronic Cigarette | |

Alcohol Use No Yes - Frequency Daily Weekly Monthly Occasionally Rarely

Recreational Drug Use No Yes - Marijuana Methamphetamine Cocaine Heroin Opiates Other: _____

Confidential History

**As a federal facility we are required to ask the following questions for reporting purposes. This is for statistical use only and your personal information will not be released to any outside party. This section is optional.*

Gender Identity – What is your internal sense of your gender? Do you think of yourself as:

- Male
- Female
- Male Transgender/Female to Male
- Female Transgender/Male to Female
- Other
- Refuse to report

Sexual Orientation – How you identify your physical and emotional attraction to others? Do you think of yourself as:

- Straight (not gay or lesbian)
- Gay or lesbian
- Bisexual
- Something Else
- Don't Know
- Refuse to report