ADULT MEDICAL

COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI

REGISTRATION FORM

PATIENT INFORMATION					
Last Name: First Name:	MI:	Sex: ☐ M ☐ 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? ☐ Yes ☐ No		
Preferred Language: ☐ English ☐ Spanish ☐ Other:	Interpreter Required? ☐ Yes ☐ No		Are you a Veteran? ☐Yes ☐No		
Primary Care Physician:	Primary Dental Provider:				

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

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

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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

Community Health Center of Central Missouri

HIPAA AGREEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (õHIPAAö), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I understand I can request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please list below any individuals you would like to have access to your medical records. Anyone who is not listed on this form will be unable to access any information about your healthcare.

Minor Consent: If the patient is a minor, please also indicate if this individual has your consent to bring the child to any scheduled visits in your absence. In the event any adult not listed below brings the child for care, we will be required to reschedule the appointment.

I, ____________________________, give my permission for the Community Health Center staff to discuss all health information with:

Name	Relationship to patient	I consent for the below to accompany my child to any appointments (please check all that apply; for patients age 17 and under only)

Name (Print): ____ Relationship to Patient: ____________________

Signature: ____ Date: __________________________

Patient Portal

To sign up for our patient portal, please provide us your email below (one letter per box). A patient advocate will provide you with the login information needed to activate your account. The portal offers us another way to communicate with you on your healthcare services and send you information such as lab results.

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 addition, 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 wiring, 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.

☐ Allergies _________
☐ Anemia ________
☐ Anxiety ________
☐ Arthritis ________
☐ Asthma ________
☐ Benign Prostatic Hypertrophy _______
☐ Blood Clots ________
☐ Cancer ________
☐ COPD ________
☐ Depression ________
☐ Diabetes ________
☐ High Cholesterol ________
☐ Gallbladder Disease ________
☐ Acid Reflux ________
☐ Headache, migraine ________
☐ Heart Trouble ________
☐ Hepatitis/liver disease ________
☐ High Blood Pressure ________
☐ Irritable Bowel Disease ________
☐ Osteoporosis ________
☐ Kidney Disease________
☐ Seizure Disorder ________
☐ Stroke ________
☐ Thyroid Disease ________
☐ Other: _____________________
☐ Other: _____________________

Surgical History

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

☐ Heart Stent ________
☐ Appendix Removed________
☐ Arthroscopy ________
☐ Back Surgery ________
☐ Blood Transfusion ________
☐ Heart Bypass ________
☐ Cardiac Pacemaker ________
☐ Carpal Tunnel Release ________
☐ Cataract Extraction ________
☐ Gallbladder Removed ________
☐ Colon Removed ________
☐ Colon Surgery ________
☐ Gastric Bypass ________
☐ Hernia Repair ________
☐ Hip Replacement ________
☐ Hysterectomy ________
☐ Knee Replacement ________
☐ LASIK ________
☐ Joint Surgery (ORIF) ________
☐ Thyroidectomy ________
☐ Tonsillectomy ________
☐ Other: _____________________
☐ Other: _____________________
☐ Other: _____________________
☐ Other: _____________________

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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)

☐ ADD/ADHD ________________________
☐ Alcoholism________________________
☐ Allergies__________________________
☐ Alzheimer's________________________
☐ Asthma __________________________
☐ Blood Disorder_____________________
☐ Cancer___________________________
☐ Depression________________________
☐ Developmental Delay________________
☐ Diabetes__________________________
☐ Eczema___________________________
☐ High Cholesterol___________________
☐ Genetic Disease____________________
☐ Hearing Deficiency__________________________
☐ Heart Trouble______________________________
☐ High Blood Pressure_________________________
☐ Irritable Bowel Disease______________________
☐ Learning Disability__________________________
☐ Mental Illness______________________________
☐ Migraines__________________________________
☐ Obesity____________________________________
☐ Osteoporosis_______________________________
☐ Kidney Disease_____________________________
☐ Seizures___________________________________
☐ Stroke_____________________________________
☐ Thyroid Disorder___________________________

Diagnostic/Screening Studies

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

☐ Mammogram ______________________________
☐ Pap Smear ________________________________
☐ Colonoscopy ______________________________
☐ 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)

☐ Cigarettes ______ How many packs per day? ____
☐ Cigarello ______
☐ Cigar______
☐ Pipe ______
☐ Electronic Cigarette
☐ Chewing ______
☐ Smokeless ______
☐ Snuff ______
☐ Other: ___________________________

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