Adult Medical

COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	MI:	Birth Sex: ☐ M ☐ F	Birth date: / /	Social Security Number:
Mailing Address:	City, State:		Zip Code:		
Home Phone: ( )	Cell Phone: ( )	Email Address:			

Race (Circle One) White/ Black or African American/ Multi-racial/ American Indian or Alaska Native
Asian/ Asian Indian/ Hawaiian or Pacific Islander/ Other Pacific Islander not Hawaiian
Chinese/ Filipino/ Korean/ Vietnamese/ Other Asian/ Guamanian or Chamorro
Samoan/ Other

Ethnicity (Circle One) Hispanic or Latino/ Mexican
Mexican American/ Chicano/ Puerto Rican
Cuban/ Other Hispanic or Latino Origin
Not Hispanic or Latino Origin

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 ☐ Legal 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

EMERGENCY CONTACT

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

INSURANCE

(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:**

AS A FEDERAL FACILITY WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS

ANNUAL INCOME - *Locate your family size and circle the income range in that row that best fits your household.*

Family Size	☐ Refuse to report - please initial _____				
1	$0 - $15060	$15061-$22590	$22591-$26355	$26356-$30120	$30121 and up
2	$0 - $20440	$20441-$30660	$30661-$35770	$35771-$40880	$40881 and up
3	$0 - $25820	$25821-$38730	$38731-$45185	$45186-$51640	$51641 and up
4	$0 - $31200	$31201-$46800	$46801-$54600	$54601-$62400	$62401 and up
5	$0 - $36580	$36581-$54870	$54871-$64015	$64016-$73160	$73161 and up
6	$0 - $41960	$41961-$62940	$62941-$73430	$73431-$83920	$83921 and up
7	$0 - $47340	$47341-$71010	$71011-$82845	$82846-$94680	$94681 and up
8	$0 - $52720	$52721-$79080	$79081-$92260	$92261-$105440	$105441 and up

For patients 12 and older only

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 do 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

By signing below I agree that the above information is accurate and true to the best of my knowledge:

Patient/Guardian Signature:	Date:

Patient Name: _____ DOB: _____

GENERAL POLICIES AND CONSENTS

APPOINTMENT TIMES

It is important you show up to all appointments on time. All **new patients** are required to check in at least 30 minutes prior to their appointment. All **established patients** must check in at least 15 minutes prior to their appointment. This will allow time to complete all 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. Failure to check in timely will result in the need to be rescheduled.

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

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. A missed appointment includes any appointment for which the patient does not present to the designated clinic/location, an appointment not cancelled/rescheduled at least 24 hours in advance and showing up for an appointment late necessitating a reschedule.

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.

FAMILY PRACTICE/PEDIATRICS/OBGYN/MENTAL HEALTH

In the event of excessive missed appointments, CHCCMO has the right to grant care on an emergency or walk in basis only.

DENTAL

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.

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.

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

_____ _____

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE DATE

Patient Name: _____ DOB: _____

HEALTH INFORMATION EXCHANGE CONSENT

The Health Information Exchange (HIE) allows multiple healthcare provider to link by electronic medical records. When going 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 to prove they have a treatment relationship with you as a patient before the HIE will allow access to information. An HIE is important because sharing information improves care. Community Health Center of Central Missouri Partners with the following HIEs:

- Tiger Institute Health Information Alliance
- Carequality/SureScripts

You can choose to if you want to participate in the HIE. The care you receive from providers at CHCCMO is not dependent on whether you choose to participate in the HIE. With this form you may choose from 2 options:

Option 1 - Opt In

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 the above HIEs.

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.

Option 2 - Opt Out

By signing this form you acknowledge that you understand the statements below:

- I understand that I am signing this form because I do not want my health records shared with my providers and health care team members through the HIEs listed above.
- I understand that this opt-out form only applies to the HIEs listed above that Community Health Center of Central Missouri participates in and does NOT cover or affect my opting out of any other HIE.
- I may choose to join the HIEs that Community Health Center of Central Missouri participates in at any time by signing an HIE Request to Opt-In form.
- I understand that by opting out of the above HIEs, my providers will not have immediate access to critical information about my health accessible through these HIEs. This may impact my provider's ability to see a complete picture of my health which could limit their ability to make the best possible decisions about my care.
- This request can take up to 3-5 business days to take effect.

☐ **Opt In – I choose to Opt-in to the HIE; I give consent for CHCCMO to share all health information through the HIE. This authorization is valid until revoked by me in writing, and it will be effective the date received.**

☐ **Opt Out – I am choosing to Opt-out of the HIE; I am requesting none of my health information be shared through the HIE.**

PATIENT, PARENT, OR LEGAL GUARDIAN SIGNATURE	RELATIONSHIP TO PATIENT	DATE

WITNESSED BY	DATE

Name:_____
DOB:_____

Community Health Center of Central Missouri

HIPAA AGREEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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*.

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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.

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

Name	Relationship to patient

Name (Print): _____ Relationship to Patient: _____

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

MEDICAL 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 Disorder _____
☐ 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: _____

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)

☐ 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: _____