



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

PATIENT INFORMATION						
Last Name:		First Name:		MI:	Birth Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /
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				Are you Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please further specify (circle one): Mexican/Mexican American/ Chicano/ Puerto Rican Cuban/ Other Hispanic or Latino Origin		
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:			Do you need information on Advance Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No	
GUARANTOR INFORMATION						
Name of Responsible Party:		Birth date: / /	Relationship of Responsible Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal 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		
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 <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:		
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.						
Although we are not a free clinic, we offer discounted (nominal) fees to eligible patients. Providing the below can help us determine eligibility for such programs.						
Family Size						
1	\$0 - \$15,960	\$15,961 - \$23,940	\$23,941 - \$27,930	\$27,931 - \$31,920	\$31,921 and up	
2	\$0 - \$21,640	\$21,641 - \$32,460	\$32,461 - \$37,870	\$37,871 - \$43,280	\$43,281 and up	
3	\$0 - \$27,320	\$27,321 - \$40,980	\$40,981 - \$47,810	\$47,811 - \$54,640	\$54,641 and up	
4	\$0 - \$33,000	\$33,001 - \$49,500	\$49,501 - \$57,750	\$57,751 - \$66,000	\$66,001 and up	
5	\$0 - \$38,680	\$38,681 - \$58,020	\$58,021 - \$67,690	\$67,691 - \$77,360	\$77,361 and up	
6	\$0 - \$44,360	\$44,361 - \$66,540	\$66,541 - \$77,630	\$77,631 - \$88,720	\$88,720 and up	
7	\$0 - \$50,040	\$50,041 - \$75,060	\$75,061 - \$87,570	\$87,571 - \$100,080	\$100,080 and up	
8	\$0 - \$55,720	\$55,721 - \$83,580	\$83,581 - \$97,510	\$97,511 - \$111,440	\$111,440 and up	
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 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 may 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

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 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.

In the event of excessive missed appointments, CHCCMO has the right to grant care on an emergency or walk in basis only. For dental patients, please refer to the Dental Consents for further information on policies specific to dental.

FINANCIAL AGREEMENT

Payment is expected at the 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

I understand my provider will recommend a treatment plan aimed at improving my health and wellbeing. 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 understand that noncompliance with recommended treatment could result in worsening of my condition or an increased risk of complications. 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.

PATIENT CONDUCT

CHCCMO is committed to providing a safe environment for all patients, employees and visitors. Violent, aggressive, or verbally abusive behavior will not be tolerated and may result in removal from the premises.

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

DENTAL DEPARTMENT POLICIES AND CONSENTS

CONFIRMATION POLICY

I understand that scheduling an appointment requires me to commit to confirm and attend the appointment. If the clinic cannot confirm my appointment by phone or text **at least 24 hours in advance, the appointment will be cancelled** and filled by other patients. I understand that if my phone number changes it is still my responsibility to reach out to the clinic and confirm my appointment. I may reappoint by calling the clinic, but this same limitation will still apply, meaning I must confirm the appointment by phone or text.

NO SHOWS

After your initial missed appointment, any future appointments will be cancelled and rescheduled one at a time. **Any patient who has 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.

GENERAL DENTAL CONSENT

I authorize CHCCMO to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE

DATE

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

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 or 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 CHCCMO to be able to talk to about your (or your dependent’s) care, treatment, payment, or appointments. For minors, please ensure all legal custodial guardians are listed. Anyone who is not listed on this form will be unable to access any information about your healthcare. CHCCMO will ask these persons to identify themselves before sharing any PHI.

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

Name	Relationship to patient

PRINT NAME

RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN

DATE

Welcome to the Community Health Center – Tell Us About Yourself

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you have a Guardian? Yes No If yes, who? _____

Do you use tobacco in any form? Yes No

What form of tobacco? _____ Are you interested in quitting? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Have you ever had any surgical procedures? Yes No

Please list each one: _____

Medical History

Yes No Conditions

Abnormal Bleeding

ADD/ADHD

Alcohol Abuse

Anemia

Angina Pectoris

Anxiety

Arthritis

Artificial Heart Valve

Asthma

Autism

Bisphosphonate Therapy

Blood Transfusion

Cancer

Chemotherapy

Cognitive Disability

Congenital Heart Defect

COPD

Depression

Diabetes

Difficulty Breathing

Drug Abuse

Emphysema

Fainting Spells

Fever Blisters

Frequent Headaches

Glaucoma

HIV/AIDS

Heart Attack

Heart Murmur

Heart Surgery

Hemophilia

Hepatitis C

High Blood Pressure

Joint Replacement

Kidney Problems

Liver Disease

Low Blood Pressure

Mitral Valve Prolapse

Pace Maker

Psychiatric Problems

Radiation Therapy

Rheumatic Fever

Seasonal Allergies

Seizures

Sexually Transmitted Disease

Shingles

Sickle Cell Disease

Sinus Problems

Stroke

Thyroid Problems

Ulcers

Infective Endocarditis

Yes No Allergies

Alpha-gal

Aspirin

Codeine

Dental Anesthetics

Erythromycin

Jewelry

Latex

Metals

Penicillin

Tetracycline

Other: _____

Yes No For Females Only

Are you taking Birth Control Pills?

Are you pregnant?

If so, # of Weeks _____

Are you nursing?

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the dentist should be aware of that was not discussed above:

CHIEF DENTAL COMPLAINT:
PLEASE LIST

ARE YOU CURRENTLY HAVING PROBLEMS WITH DENTAL PAIN OR PAIN
MANAGEMENT..... YES NO

IF SO – HOW SEVERE IS IT ON A SCALE OF 1-10 WITH 10 BEING WORST..... 1 2 3 4 5 6 7 8 9 10

I certify that I have read the above information and it is true to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____