Gyn

COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
REGISTRATION FORM

PATIENT INFORMATION

Last Name: **First Name:** **MI:**

Birth Sex: ☐ M ☐ 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? ☐ Yes ☐ No
If yes, please further specify (circle one):
Mexican/Mexican American/ Chicano/ Puerto Rican Cuban/ Other 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:** **Do you need information on Advance Directives?** ☐ Yes ☐ No

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.***
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:**

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 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

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

Patient Name: ______________________________ DOB: __________________

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*.

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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

Patient Name: ________________________________ DOB: ____________

GYN INITIAL EVALUATION

Medications

Preferred Pharmacy: ____

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

____

____

____

Allergies

☐ No Known Allergies

List any allergies and the allergic reaction.

____

____

Gynecologic History

Age of first period: _________ First Day of Last Period: _____________

Periods come every _________________ days and usually last ________________ days.

Excessive Bleeding? ☐Yes ☐No If yes, explain:____

____

Menopausal stage: ☐ Premenopausal (no menopause symptoms) ☐ Perimenopausal (some menopause symptoms)

☐ Postmenopausal – Age/Year ________________

Last Pap: ____ Do you have a difficult time with pelvic exams? ☐Yes ☐No

Last Mammogram: ____ Do you perform self-breast exams? ☐Yes ☐No

Contraceptive/Sexual History

Please check any birth control methods you have used in the past:

☐Birth Control Pills
☐Depo-Provera
☐Natural Family Planning
☐Partner had Vasectomy
☐Condoms
☐Intrauterine Device
☐Tubal Ligation
☐Withdrawal
☐Other, please explain:

Are you currently on birth control? ☐Yes (specify kind): ______________________________________☐No

Do you desire birth control today? ☐Yes (specify kind): ____☐No

Answers to the following questions will help your provider provide appropriate care and identify potential risks for cervical cancer. Leave any questions blank if you are uncomfortable answering them.

Are you or have you been sexually active? ☐Yes ☐No If yes, have your partners been: ☐men ☐women ☐both

Number of partners in the last year _____________ Number of total lifetime partners ______________

Are there any aspects of your sexual lifestyle which might have bearing on your care i.e. sexual orientation, new partner in the last three months, or more than one partner in the last three months, etc? ☐Yes ☐No

Does your partner have any symptoms of an infection? ☐Yes ☐No

Pregnancy History (*If you have never been pregnant, please skip this section*)

Total number of pregnancies _____ Number of deliveries _____ Abortions _____ Miscarriages ___________

GYN History

Have you ever had, or do you have any of the following:

☐ Chlamydia
☐ Genital herpes
☐ Gonorrhea
☐ Abnormal pap smear
☐ Bartholin's gland cyst
☐ Breast lump
☐ Cystocele
☐ Endometriosis
☐ Urinary incontinence
☐ Fibroid uterus
☐ Infertility
☐ Ovarian cyst
☐ Pelvic inflammatory disease
☐ Polycystic ovary syndrome
☐ Prolapsed uterus
☐ Vaginal infection, recurrent
☐ Bilateral oophorectomy
☐ Other:
☐ Bilateral tubal ligation
☐ Blood transfusion
☐ Breast augmentation
☐ Breast reduction
☐ D&C
☐ Hysterectomy
☐ Removal uterine fibroids
☐ Bladder surgery

Patient Name: ________________________________ DOB: ____________

Medical History

Have you ever had, or do you have any of the following:

☐Anemia
☐Autoimmune disease
☐Cancer (include type) _______________
☐ Clotting disorder
☐ Diabetes (include type) _____________
☐ Hypercoagulable disorder
☐ Hypertension
☐ Mental disorder
☐ Obesity
☐ Pulmonary embolism/DVT
☐ Renal disease
☐ Seizure disorder
☐ Stroke
☐ Thyroid disease
☐ Urinary tract infections
☐ Other:
☐ Other:

Surgical History

Have you ever had the following performed:

☐Angioplasty
☐Appendectomy
☐Arthroscopy
☐ Back surgery
☐ Gastric bypass
☐ Hernia repair
☐ Thyroidectomy
☐ Other:

Family History

Father ☐ Alive and Well ☐ Deceased – Cause? ____
Mother ☐ Alive and Well ☐ Deceased - Cause? ____

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

☐ Alcoholism _______________________________
☐ Asthma_______________________________
☐ Autoimmune disease_______________________________
☐ Cancer (include type)_______________________________
☐ Cardiovascular disease _____________________________
☐ Coagulopathy_____________________________
☐ Depression_______________________________
☐ Other: _________________________
☐ Diabetes (include type)_____________________
☐ Hypertension_____________________________
☐ Kidney disease____________________________________
☐ Mental illness____________________________________
☐ Sickle cell____
☐ Stroke_______________________________________
☐ Thyroid Disorder__________________________

Social History

Tobacco Use (Check One) ☐ Ex-Smoker ☐ Never Used ☐ Current User ☐ Chewer
Alcohol Use ☐ No ☐ Yes - Frequency ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely
Recreational Drug Use ☐ No ☐ Yes - ☐ Marijuana ☐ Methamphetamine ☐ Cocaine ☐ Heroin ☐ Opiates ☐ Other: ___________