



**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

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

Patient Name: _____

**COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
OB PATIENT MEDICAL HISTORY FORM**

MEDICATIONS (Please list all current medications, vitamins and herbal supplements. Also list any medications you have taken during your pregnancy even if discontinued.)

Medication	Reason for Medication	Amount/Dose	How Many Times Daily	Who Prescribed?

MEDICATION ALLERGIES (Please list all allergies; include allergies to latex & iodine/betadine.)

No known drug allergies

Drug Name	Reaction

Allergy to latex No Yes

SCREENING HISTORY

Screening Test	Date Last Performed	Results
PAP Smear		
Mammogram		
Cholesterol		
Diabetes Testing		
STD Screening		

MENSTRUAL HISTORY

First day of your last period: ____/____/____ Definite Date Approximate Date Date Unknown

Menses Regular Irregular

On contraception at time of conception? No Yes – What kind? _____

Date of first positive pregnancy test ____/____/____

PREGNANCY HISTORY (If you have never been pregnant please skip this section.)

Total number of pregnancies (including this one) _____ Tubal/Ectopic Pregnancies _____

Number of deliveries _____ Miscarriages _____

Abortions _____ Number of living children _____

Number of premature deliveries _____

Patient Name: _____

Children:

Gender	Date of Birth	Name	Approx. Wks Born At	Birth Weight	Delivery Type (Vaginal or C-section)	Anesthesia	Complications	Place of Delivery	Provider Name

Do all of you children current live with you? Yes No – Please explain: _____

CURRENT PREGNANCY

Was this a planned pregnancy? No Yes

Is this your first prenatal visit for this pregnancy? No Yes

If no, please indicate where care was received prior to today: _____

Father of Baby Name: _____

Is he aware of this pregnancy? Yes No Does he plan to be involved? Yes No Do you need info on paternity testing? Yes No

HISTORY IMPORTANT TO PREGNANCY (Please check all that apply to you.)

Medical:

- Diabetes – any kind
- High blood pressure
- Heart disease or heart defect
- Autoimmune disorder (lupus, multiple sclerosis, rheumatoid arthritis)
- Kidney disease/recurrent UTI
- Neurologic/epilepsy/seizures
- Psychiatric or mental health
- Hepatitis/liver disease
- Thyroid problems
- Trauma/violence
- Physical/sexual abuse
- Other: _____
- History of blood transfusions
- D(Rh) sensitized
- Pulmonary (TB, Asthma)
- Breast
- GYN surgery
- Operations/hospitalizations
- Anesthetic complications
- Abnormal PAP smear
- Uterine malformation
- Infertility
- Cervical procedures – D&C, LEEP, conization, cryotherapy or cauterization, cerclage

Infection:

- Live with someone with TB or exposed to TB
- Yourself or partner have genital herpes
- Rash or viral illness since last period
- Hepatitis B
- Hepatitis C
- Sexually transmitted infection
- HPV
- Gonorrhea
- HIV
- Other: _____
- Chlamydia
- Syphilis
- Genital warts
- Have more than one recent sexual partner
- Prostitution
- Have sex with men who have sex with other ment
- Previous baby or pregnancy complicated by group B strep
- Chicken Pox
- Eat more than 2 servings of fish per week

Patient Name: _____

OTHER PERSONAL MEDICAL HISTORY (Please indicate any other **current/prior** medical problems that apply to you.)

- Anemia
- Cancer: _____
- Clotting disorder
- High cholesterol
- Endometriosis
- Fibroid uterus
- Gallbladder disease
- Sickle Cell
- Incompetent cervix
- Pelvic inflammatory disease/infection
- Polycystic ovaries
- Pulmonary embolism
- Recurrent vaginal infections

SURGICAL HISTORY (Please list **ALL** past surgeries)

Procedure/Surgery	Date

GENERAL QUESTIONS

- If needed, do you consent to receive a transfusion? Yes No
- Are you interested in having your tubes tied, tubal ligation after the baby is born? Yes No
- Do you plan to Breastfeed Bottle Feed Both
- Do you have cats in the home? Yes No
- Do you use a seatbelt? Yes No

FAMILY HISTORY (Please indicate any that apply to your **immediate family** and which member is/was affected.)

- | | |
|-------------------------------|---------------------------|
| Alcoholism _____ | High cholesterol _____ |
| Asthma _____ | High blood pressure _____ |
| Autoimmune disorder _____ | Mental illness _____ |
| Cancer (indicate kind) _____ | Kidney disease _____ |
| Cardiovascular disease _____ | Seizures/Epilepsy _____ |
| Bleeding disorders _____ | Spina bifida _____ |
| Coronary artery disease _____ | Stroke _____ |
| Depression _____ | Thyroid Disease _____ |
| Developmental delay _____ | Other: _____ |
| Diabetes _____ | |

SOCIAL HISTORY

- Tobacco Use** (Check One) Ex-Smoker Never Used Current Use Chewing
- Alcohol Use** No Yes - Frequency Daily Weekly Monthly Occasionally Rarely
- Caffeine Intake** 1-2 drinks/day 3 or more drinks/day
- Recreational Drug Use** No Yes - Marijuana Methamphetamine Cocaine Heroin Opiates
- Other: _____
- Exercise** 1-2 times/week 3 or more times per week None Sporadic

GENETIC SCREENING (Please check any below that applies to yourself, the baby's father, or anyone in either family.)

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Patient's age is 35 years or older |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Italian, Greek, Mediterranean or Asian Background |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Neural defect (meningomyelocele, spina bifida or anencephaly) |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Congenital heart defect |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Down syndrome- |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Tay-sachs (Jewish, Cajun, French Canadian) |
| <input type="checkbox"/> Patient <input type="checkbox"/> Baby's Father <input type="checkbox"/> Relative | Canavan disease (Jewish) |

Patient Name: _____

- Patient Baby's Father Relative
- Patient Baby's Father Relative
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- Familial dysautonomia (Jewish)
- Sickle cell disease or trait
- Hemophilia or other blood disorders
- Muscular dystrophy
- Cystic fibrosis
- Huntington's chorea
- Mental retardation/autism
- Other inherited genetic or chromosomal disorder
- Maternal metabolic disorder (Type 1 diabetes, PKU)
- Patient or baby's father had child with birth defect not listed above
- Recurrent pregnancy loss or stillbirth

ADDITIONAL CONCERNS

- Yes No Are you interested in Down Syndrome or chromosomal abnormality screening for your baby?
- Yes No Are you interested in spine defect or Spina Bifida screening for your baby?
- Yes No Are you interested in Cystic Fibrosis screening?
- Yes No Do you want more information on breast feeding?
- Yes No Do you need a breast pump?
- Yes No Do you have a social or case worker that helps with your family?– If Yes name and contact info: _____

- Yes No Are you interested in talking with a social worker?
- Yes No Are you interested in talking to a mental health counselor?
- Yes No Are you interested in a Drug Rehabilitation Program?
- Yes No Are you interested in adoption?
- Yes No Are you interested in terminating this pregnancy?
- Yes No Are you interested in seeing our dentist?

Patient Signature: _____

Date: _____

.....
(Do not write in this section)

PRENATAL DENTAL

LMP

EDC

APPOINTMENT

PROVIDER

PREVIOUS CHCCMO PROVIDER

HOSPITAL

HOSPITAL PREFERENCE
