



**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 |
| Mailing Address: | | | City, State: | Birth date: / / | |
| 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 Medical 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 Medical 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 Dental 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 Dental 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

Patient Name: _____

DOB: _____



**Community Health Center of Central Missouri
TREATMENT AUTHORIZATION AND CONSENT
FORM FOR MINORS OR WARDS**

The following form is designed for those situations where a parent or legal guardian cannot be present with a minor/ward at the time of their visit. This consent gives authority for up to 5 designated adults to bring the minor/ward to his or her appointment, consent to care, and arrange for future visits. This consent is valid for a period of 12 months from the date of signature at which time the parent or guardian must be present to provide new authorization in writing. Any minor/ward presenting without an authorized adult will be required to reschedule the appointment.

Exception: For services related to birth control, a parent or guardian is required to be present.

I _____ authorize the following individual(s) to bring
Parent/Guardian Full Name

_____ to appointments and consent to care as deemed
Minor/Ward Full Name

necessary by the provider:

1. _____
2. _____
3. _____
4. _____
5. _____

Parent or Guardian Signature

Relationship

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

PEDIATRIC HEALTH HISTORY

Patient Name: _____

DOB: _____

Date: _____

Primary Care Physician and Date of last visit: _____

Dentist and Date of last visit: _____

Pharmacy: _____

Current Problem: _____

Please list current medications: _____

Any allergies to the following; if yes indicate reaction:

| | | | | | | | | |
|-------------------|-----|----|-------------|-----|----|--------------|-----|----|
| Dental Anesthetic | Yes | No | Penicillin | Yes | No | Metals | Yes | No |
| Latex | Yes | No | Clindamycin | Yes | No | Codeine | Yes | No |
| Acetaminophen | Yes | No | Aspirin | Yes | No | Tetracycline | Yes | No |

Other Allergies: (Include Drug, Reaction, and Age of Onset): _____

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____
 Discharge Weight: _____ Gestational Age at Birth (weeks): _____
 Delivery Method: Vaginal C-Section If C-Section, why? _____ Duration of Labor: _____
 APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____
 Infant Feeding: Breast Bottle Both Formula Name: _____
 Newborn Hearing Screening: Pass Fail Other Comments: _____

Medical History: (Check Appropriate Box and Comment in Margins)

| | | | | | |
|---|-----|----|--------------------------------|-----|----|
| ADD/ADHD _____ | Yes | No | Prematurity _____ | Yes | No |
| Anemia _____ | Yes | No | Asthma _____ | Yes | No |
| Congenital Heart Disease _____ | Yes | No | Constipation _____ | Yes | No |
| Developmental Delay _____ | Yes | No | Diabetes _____ | Yes | No |
| Eczema _____ | Yes | No | Food Allergies _____ | Yes | No |
| GE Reflux or ulcers _____ | Yes | No | Depression _____ | Yes | No |
| Murmur _____ | Yes | No | Anxiety _____ | Yes | No |
| Recurrent Otitis (ear infections) _____ | Yes | No | Recurrent Strep Throat _____ | Yes | No |
| Seizures _____ | Yes | No | Substance Abuse _____ | Yes | No |
| UTI _____ | Yes | No | Vision Problems _____ | Yes | No |
| Kidney Problems _____ | Yes | No | Wheezing _____ | Yes | No |
| Seasonal Allergies _____ | Yes | No | Blood Clotting Disorders _____ | Yes | No |
| Sinus Problems _____ | Yes | No | Thyroid Problems _____ | Yes | No |
| Stroke _____ | Yes | No | | | |

Other Medical History: _____

Surgical History: (Check Appropriate Box)

| | Yes | No | Date | Surgeon |
|----------------------------------|-----|----|------|---------|
| Adenoidectomy (adenoids removal) | Yes | No | | |
| Appendectomy (appendix removal) | Yes | No | | |
| Ear Tubes | Yes | No | | |
| Fundoplication | Yes | No | | |
| Gastrostomy Tube Placement | Yes | No | | |
| Heart Surgery | Yes | No | | |
| Hernia Repair | Yes | No | | |
| Orthopedic Surgery | Yes | No | | |
| Tonsillectomy | Yes | No | | |
| Urologic Surgery | Yes | No | | |
| VP Shunt | Yes | No | | |

Other Surgical History: _____

Patient Name: _____

DOB: _____

Date: _____

Family History: (Check all boxes that apply)

| Relationship to CHILD | | A:Alive | D:Deceased | ADD/ADHD | Allergies | Anemia | Asthma | Cancer | Diabetes | Eye Disease | GI Problems | Heart Disease | High Cholesterol | Hypertension | Kidney Disease | Mental Illness | Migraines | Seizures | Substance Abuse | Thyroid Disease | Other |
|-----------------------|----------|---------|------------|----------|-----------|--------|--------|--------|----------|-------------|-------------|---------------|------------------|--------------|----------------|----------------|-----------|----------|-----------------|-----------------|-------|
| Parents | Mother | A | D | | | | | | | | | | | | | | | | | | |
| | Father | A | D | | | | | | | | | | | | | | | | | | |
| Sibs | Sister | A | D | | | | | | | | | | | | | | | | | | |
| | Brother | A | D | | | | | | | | | | | | | | | | | | |
| Aunts/ Uncles | *M Aunt | A | D | | | | | | | | | | | | | | | | | | |
| | *M Uncle | A | D | | | | | | | | | | | | | | | | | | |
| | *P Aunt | A | D | | | | | | | | | | | | | | | | | | |
| | *P Uncle | A | D | | | | | | | | | | | | | | | | | | |
| Grand- parents | *MGM | A | D | | | | | | | | | | | | | | | | | | |
| | *MGF | A | D | | | | | | | | | | | | | | | | | | |
| | *PGM | A | D | | | | | | | | | | | | | | | | | | |
| | *PGF | A | D | | | | | | | | | | | | | | | | | | |

*M=Maternal, the patient's mother's side of the family

*P=Paternal, the patient's father's side of the family

Comments (including other family medical problems): _____

Additional Family History, including other siblings, may be added below:

| Relationship to CHILD | A:Alive | D:Deceased | ADD/ADHD | Allergies | Anemia | Asthma | Cancer | Diabetes | Eye Disease | GI Problems | Heart Disease | High Cholesterol | Hypertension | Kidney Disease | Mental Illness | Migraines | Seizures | Substance Abuse | Thyroid Disease | Other | |
|-----------------------|---------|------------|----------|-----------|--------|--------|--------|----------|-------------|-------------|---------------|------------------|--------------|----------------|----------------|-----------|----------|-----------------|-----------------|-------|--|
| | A | D | | | | | | | | | | | | | | | | | | | |
| | A | D | | | | | | | | | | | | | | | | | | | |
| | A | D | | | | | | | | | | | | | | | | | | | |
| | A | D | | | | | | | | | | | | | | | | | | | |
| | A | D | | | | | | | | | | | | | | | | | | | |
| | A | D | | | | | | | | | | | | | | | | | | | |

Home Environment:

Number of people at Home: _____

Lives with biological parents: Yes No

Foster Care: Yes No

Primary Care Givers: Parents Daycare Relatives Other: _____

Daycare (hours/day) _____

Time at relatives (hours/day): _____

Pets: Yes No

Tobacco Use Patient Parents What form of tobacco? _____

Parent's Status:

Parent's Martial Status (circle): Married Divorced Living Together Friends Father in Jail

Mother in Jail Never Together Separated Other: _____

Mother's Occupation: _____

Father's Occupation: _____