# 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: | County: |
|---|---|---|---|
| | | | |

| Home Phone: ( ) | Cell Phone: ( ) | Email Address: |
|---|---|---|
| | | |

**Race (Circle One)** White/ Black or African American/ American Indian or Alaska Native/ Asian/ Hawaiian or Pacific Islander/ Multi-racial/ Other:

**Ethnicity:** Hispanic or Latino origin? ☐ Yes ☐ No

**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/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 | | | | | |
|---|---|---|---|---|---|
| 1 | $0 - $12490 | $12491 - $18735 | $18736 - $21858 | $21859- $24980 | $24981 and up |
| 2 | $0 - $16910 | $16911 - $25365 | $25366 - $29593 | $29594 - $33820 | $33821 and up |
| 3 | $0 - $21330 | $21331 - $31995 | $31996 - $37328 | $37329 - $42660 | $42661 and up |
| 4 | $0 - $25750 | $25751 - $38625 | $38626 - $45063 | $45064 - $51500 | $51501 and up |
| 5 | $0 - $30170 | $30171 - $45255 | $45256 - $52798 | $52799 - $60340 | $60341 and up |
| 6 | $0 - $34590 | $34591 - $51885 | $51886 - $60533 | $60534 - $69180 | $69181 and up |
| 7 | $0 - $39010 | $39011 - $58515 | $58516 - $68268 | $68269 - $78020 | $78021 and up |
| 8 | $0 - $43430 | $43431 - $65145 | $65146 - $76003 | $76004 - $86860 | $86861 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: |
|---|---|
| | |

# GENERAL POLICIES AND CONSENT

## APPOINTMENT TIMES

All **new patients** are required to check in at least 30 minutes prior to their appointment. This allows the patient time to complete the required paperwork and allows the staff to have the patient in the exam room by the appointment time.

All **established patients** must check in at least 15 minutes prior to their appointment. This will allow the patient time to update any 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.

You will receive a phone call reminding you of your appointment time two days prior to your scheduled visit. It is important you provide a working telephone number and inform us of any changes so we are able to remind you of your visit.

**Any patient who does not check in by the times listed above will need to be rescheduled.**

**All minors (children aged 17 and under) must be accompanied by a parent or legal guardian at <u>all</u> appointments.**

## 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.

## 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.

You will be notified of a missed appointment in one of the following methods; phone call or a letter.

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.

**Continued on next page…**

**MISSED APPOINTMENTS CONTINUED…**

*FAMILY PRACTICE/PEDIATRICS/OB/GYN/MENTAL HEALTH*

You will be allowed 3 no shows (failure to present to clinic) for the above appointment types at which time you will not be allowed to schedule an appointment for a period of 1 year. You will still be granted care on an emergent basis as a walk-in only without guarantee of being seen the day you come in.

*DENTAL*

For dental appointments, a missed appointment is defined as follows:

1. Any appointment for which the patient does not present to the designated clinic/location
2. Any appointment cancelled with less than 24 hours' notice
3. Showing up for an appointment 10 or more minutes late, necessitating the appointment be rescheduled
4. Showing up without appropriate payment that was previously quoted resulting in appointment needing rescheduled
5. Minor who shows up without accompanying adult specified on recent patient paperwork

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.

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

_____ _____

PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE DATE

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*.

.

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: _____

# Health Information Exchange Opt In

Printed Name: _____ Date of Birth: _____
Street Address:_____City:_____
State:_____ Zip:_____Phone:_____

**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 and from the following HIEs:**

- **Tiger Institute Health Information Alliance**
- **Carequality/SureScripts**

**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.**

## ACKNOWLEDGEMENT OF UNDERSTANDING:

-I understand that the HIE allows multiple healthcare provider to link by electronic medical records. When I go 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 about me to prove they have a treatment relationship with me before the HIE will allow access to my information.

This authorization will remain in place until revoked by me. I understand that I may revoke this authorization at any time by notifying the Community Health Center of Central Missouri in wiring, and it will be effective on the date received. However, it will not have any effect on actions already taken by my healthcare providers in reliance on this written authorization to release my medical information.

Signature of Patient and/or Legal Guardian:_____

Relationship to Patient:_____ Date:_____

Witnessed By:_____ Date:_____

COMMUNITY HEALTH CENTER of Central Missouri
Embracing people, inspiring health.

3400 West Truman Blvd
Jefferson City, MO 65109
Phone (573) 632-2777
Fax (573) 644-7924

# Informed Consent for Local Anesthetics

Patient Name: _____ Date of Birth:_____

This consent form is designed to make you aware of the risks involved with local anesthesia which is commonly used prior to dental treatment. The risks include, but are not limited to:

- The risk that anesthesia may affect your body such as, dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions. Any or all of these may require additional medical management or hospitalization and in very rare instances could result in death.
- Restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection, which often resolves after a few days, but may require physical therapy.
- Local anesthesia may cause prolonged numbness that, in some patients, may result in injury from biting, chewing, or sucking an area such as the lip, cheek, tongue, or any other area that has received the anesthesia.
- Injury to the nerves is possible that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. While normally wearing away after a few hours, this may persist for several weeks, months, or rarely, be permanent. If you are still numb 24 hours after your appointment, please contact us so proper follow up can be initiated.
- Local anesthesia is administered with a very fine needle. In very rare instances these needles may break off and be lodged in soft tissue, especially if a patient moves while anesthesia is being given. This may require the patient to be seen by an oral surgeon to remove the needle.
- Hematoma (large bruise) formation is possible which can cause tissue discoloration, swelling, difficulties in opening/closing the jaw, and/or pain and stiffness.

I have read and fully understand this consent form. I understand that I should not sign this form if all items, including all my questions have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

| _____ | _____ | _____ |
|---|---|---|
| Patient or Parent/Guardian Signature | Date | Relationship to Patient |
| _____ | _____ | |
| Witness Signature | Date | |
| _____ | _____ | |
| Interpreter Signature | Date | |

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# Informed Consent for General Dental Procedures

Patient Name: _____ Date of Birth:_____

You have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your or such patient's physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by the dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

This form is intended to provide you with an overview of potential risks and complications of your or the above-listed patient's dental procedure(s). Do not sign this form or agree to treatment until you have read, understood, and accepted each term of this Informed Consent for General Dental Procedures. Please discuss the potential benefits, risks, and complications of recommended treatment with the dentist. Be certain all of your concerns have been addressed to your satisfaction by the dentist before commencing treatment and signing this Informed Consent for General Dental Procedures.

**Dental Procedures:** The above-named patient, (or _____ parent or legal guardian of the above-named patient), authorizes CHCCMO and its dental staff to perform the following dental procedures and/or treatment on the patient, including, but not limited to: dental examination, dental prophylaxis, fluoride treatment, x-rays, restorations, periodontal therapy such as scaling and root planing, primary tooth pulpal therapy, placement of stainless steel crowns in the primary or permanent dentition, alveoplasty, extractions, frenectomy, crowns, bridges, endodontic therapy, space maintenance, fabrication of removable appliances, and _____.

**Risks of Dental Procedure:** Include, but are not limited to pain, swelling and discomfort, infection, bleeding, nerve injury, blood clots, broken or cracked teeth, allergic reactions, soreness of the mouth, lips, gums, and teeth, numbness, fever, nausea, and vomiting.

**Occupational Exposure:** I consent to the withdrawal of a blood sample from me or the above-listed patient to perform tests which include, but are not limited to, HIV and Hepatitis antibodies. I understand that the blood test will be done only if a healthcare worker has an accidental needle stick or mucous membrane exposure to the blood and body fluid of the patient. I understand that the test will be done on the order of my or the above-listed patient's medical team and the results will be released to the dentist. The CHCCMO dental clinic will provide results of such tests to me and any other entities as required by law. I authorize the release of appropriate data necessary to process the testing. I understand that there will be no cost to me for this blood test.

**No Guarantee:** I understand that no guarantee or assurance has been made as to the ultimate result of any procedure.

**Patient's Consent:** I have read and fully understand this consent form. I acknowledge that my dentist has explained the commonly known risks of the recommended procedure, alternative treatments or the option of no treatment. I understand that I should not sign this form if all items, including all my questions have not been explained or answered to my satisfaction or if I do not understand any of the words contained in this form.

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Patient or Parent/Guardian Signature | Date | Relationship to Patient |
| _____ | _____ | |
| Witness Signature | Date | |
| _____ | _____ | |
| Interpreter Signature | Date | |

Patient Name: _____ DOB: _____

# 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: _____