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 all 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 (õHIPAAö), 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*.

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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.

Minor Consent: If the patient is a minor, please also indicate if this individual has your consent to bring the child to any scheduled visits in your absence. In the event any adult not listed below brings the child for care, we will be required to reschedule the appointment.

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

Name	Relationship to patient	I consent for the below to accompany my child to any appointments (please check all that apply; for patients age 17 and under only)

Name (Print): ____ Relationship to Patient: ____________________

Signature: ____ Date: __________________________

Patient Portal

To sign up for our patient portal, please provide us your email below (one letter per box). A patient advocate will provide you with the login information needed to activate your account. The portal offers us another way to communicate with you on your healthcare services and send you information such as lab results.

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 OB Clinic - Patient Medical History Information

Name:______________________________________ Date:______________ Age:________ Date of Birth:____________

Medications: (Please list **ALL** current medications, vitamins & herbal supplements)

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

Personal Medical History: Please indicate current/prior medical problems related to you.

☐ No Significant Medical Problems

___Abnormal mammogram
___Bacterial vaginosis
___Herpes
___Abnormal pap
___Breast lump/mass
___Yeast infections
___Gonorrhea
___Cervical dysplasia
___Fibrocystic breast disease
___Chlamydia
___Infertility
___Cervical cancer
___Pelvic inflammatory

___Genital warts
___Cervical polyp
___Breast cancer
___Asthma
___Seizures
___Blood transfusions
___Anxiety
___Elevated blood pressure
___Blood clots (DVT)
___Diabetes
___Stroke
___Heart attack
___Overactive thyroid

___Underactive thyroid
___Migraine headaches
___Mitral valve prolapsed
___Lupus
___Bartholin gland/cyst
___Uterine cancer
___Ovarian cysts
___Ovarian cancer
___Fibroids of the uterus
___Polycystic ovaries
___Leaking urine (urinary incontinence)

___Depression; Do you currently have little interest or pleasure in doing things?
___Depression; Are you currently feeling down, depressed, or hopeless?

Other medical problems:

____
____
____
____
____

Screening Tests:

Screening Test	Date	Results
Pap Smear		
Mammogram		
Bone Density		
Cholesterol		
Colonoscopy		

Past Surgical History: (Please list **ALL** surgeries including procedures to the cervix)

Procedure/Surgery	Date

Gynelogical History:

Age of first period: ___
Days of flow: ___
First day of last period: ______
Cycle interval (1st day of period to 1st day of next):_____

Clots with cycle: Yes No
Amount of flow: Heavy Moderate Light
Bleeding between periods: Yes No
Contraceptive method: _______
If menopausal, age at first onset: _____

Pregnancy History: (If never pregnant, please skip this section.)

Total number of pregnancies (including this one) _____
Number of deliveries _____
Abortions _____

Number of premature deliveries _____
Ectopic pregnancies _____
Miscarriages _____

Children:

Name	DOB	Birth Weight	Sex	Vaginal or C-Section	Anesthesia	Early Labor	Complications	Location	Provider

Husband's Name ___________________________________
Father of Baby Name _______________________________
Newborn Physician _________________________________

Social History: (Circle the term that best describes your habits)

Marital Status:
Married
Single
Divorced
Widowed

Alcohol Use:
Frequent
Never
Occasional

Smoker:
Current
Never
Prior

Drug use:
Current
Never
Prior

Domestic Violence:
Current
Never
Prior

Self-Breast Exam:
Irregular
Regular (monthly)
Not done at all

Caffeine Intake:
None
1-2 drinks/day
3 or more drinks/day

Calcium Intake:
1000mg calcium daily
Less than 1000mg calcium daily

Exercise:
1-2 times/week
3 or more times week
None
Sporadic

Seatbelt use:
Not regular
Always

SBIRT if Indicated

Problems Important to Pregnancy: (Please check **ALL** boxes that apply to you)
Medical Problems:

- ☐ Blood transfusions
- ☐ Deep vein clot/thrombosis
- ☐ Autoimmune disorder (lupus, Multiple Sclerosis)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Kidney disease/recurrent UTI's
- ☐ Neurological problems/epilepsy/seizures
- ☐ Psychiatric problems
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Thyroid problems
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Domestic Violence
- ☐ Trauma history
- ☐ Asthma
- ☐ Gynecologic or female surgery
- ☐ Uterine malformations
- ☐ Anesthesia complications
- ☐ Abnormal PAP smear
- ☐ Cervical procedures

Other medical problems not listed above:____

Infection History:

- ☐ Chicken Pox
- ☐ Do you change a cat's litter box?
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Live with someone with TB
- ☐ Exposed to TB
- ☐ You or your partner has a history of Genital Herpes
- ☐ Rash or viral illness this pregnancy
- ☐ History of an STD (Sexually Transmitted Disease)
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Abnormal Pap smear
- ☐ HPV (Human Papilloma Virus)
- ☐ Genital Warts
- ☐ Syphilis
- ☐ HIV or AIDS
- ☐ Have more than one recent sexual partner
- ☐ Prostitution
- ☐ Have sex with men who have sex with other men

Family History: (Please indicate your immediate family and which member is/was affected)

Cardiac disorders _______________
High blood pressure _____________
High cholesterol ________________
Bleeding disorders ______________
Cervical cancer _________________
Mental retardation ______________
Breast cancer __________________
Colon cancer ___________________
Ovarian cancer _________________

Cleft lip _______________________
Uterine cancer __________________
Cystic fibrosis __________________
Sickle Cell Anemia ______________
Down syndrome ________________
Diabetes ______________________
Heart disease __________________
Spina bifida/anencephaly ________

Genetic/Medication/Drug (Check if this applies to you **Or** family)

- ☐ Age 34 or greater
- ☐ Italian, Greek, Mediterranean, Asian background
- ☐ Neural tube/ spine defect/ anencephaly
- ☐ Heart problems in childhood or birth
- ☐ Down syndrome
- ☐ Tay-Sachs disease
- ☐ Jewish, Cajun, French Canadian background
- ☐ Sickle Cell disease or trait
- ☐ Hemophilia
- ☐ Muscular Dystrophy
- ☐ Cystic Fibrosis
- ☐ Huntington Chorea
- ☐ Mental retardation
- ☐ Autism
- ☐ Alcohol exposure this pregnancy
- ☐ Other inherited genetic or chromosomal disorder
- ☐ Metabolic disorder (diabetes, PKU, Galactosemia)
- ☐ You or the baby's Father has a child with a birth defect not listed
- ☐ Recurrent pregnancy loss/miscarriage/stillbirth
- ☐ Medication exposure this pregnancy
- ☐ Street drug exposure this pregnancy

Additional Concerns:

- ☐ Are you interested in Down syndrome screening?
- ☐ Are you interested in spine defect or Spina Bifida screening?
- ☐ Are you interested in Cystic Fibrosis screening?
- ☐ Are you interested in having your tubes tied, Tubal Ligation, vasectomy or other permanent sterilization?
- ☐ Do you want to breast feed?
- ☐ Do you want more information on breast-feeding?
- ☐ Do you want to bottle feed?
- ☐ Taking a prenatal vitamin
- ☐ Have a social worker or caseworker that helps with your family
- ☐ Interested in social work help

Patient Signature: ____ **Date: ____________________**

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(Do not write in this section)

PRENATAL DENTAL ______________

LMP _______ EDC _______

APPOINTMENT ____________

CHCCMO PROVIDER ______________

HOSPITAL ________

PREVIOUS CHCCMO PROVIDER ______________

HOSPITAL PREFERENCE __________