



**COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
REGISTRATION FORM**



PATIENT INFORMATION								
Last Name:		First Name:		MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
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:				

GUARANTOR INFORMATION					
Name of Responsible Party:		Birth date: / /	Relationship of Responsible Party to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent/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	

INSURANCE INFORMATION			
(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:

ANNUAL INCOME					
<i>Please circle next to your family size what income range best fits your household.</i>					
Family Size					
1	\$0 - \$12060	\$12061 - \$18090	\$18091 - \$21105	\$21106 - \$24120	\$24121 and up
2	\$0 - \$16240	\$16241 - \$24360	\$24361 - \$28420	\$28421 - \$32480	\$32481 and up
3	\$0 - \$20420	\$20421 - \$30630	\$30631 - \$35735	\$35736 - \$40840	\$40841 and up
4	\$0 - \$24600	\$24601 - \$36900	\$36901 - \$43050	\$43051 - \$49200	\$49201 and up
5	\$0 - \$28780	\$28781 - \$43170	\$43171 - \$50365	\$50366 - \$57560	\$57561 and up
6	\$0 - \$32960	\$32961 - \$49440	\$49441 - \$57680	\$57681 - \$65920	\$65921 and up
7	\$0 - \$37140	\$37141 - \$55710	\$55711 - \$64995	\$64996 - \$74280	\$74281 and up
8	\$0 - \$41320	\$41321 - \$61980	\$61981 - \$72310	\$72311 - \$82640	\$82641 and up

EMERGENCY CONTACT				
Name of local friend or relative:		Relationship to Patient:	Home Phone: ()	Cell Phone: ()

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



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 addiction, 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 writing, 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

- | | | |
|---|--|---|
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Underactive thyroid |
| <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Cervical polyp | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Mitral valve prolapsed |
| <input type="checkbox"/> Abnormal pap | <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Breast lump/mass | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bartholin gland/cyst |
| <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Uterine cancer |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Ovarian cancer |
| <input type="checkbox"/> Fibrocystic breast disease | <input type="checkbox"/> Blood clots (DVT) | <input type="checkbox"/> Fibroids of the uterus |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polycystic ovaries |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Stroke | <input type="checkbox"/> Leaking urine (urinary incontinence) |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Pelvic inflammatory | <input type="checkbox"/> Overactive thyroid | |

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

Gynecological 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:

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

Other medical problems not listed above: _____

Infection History:

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

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)

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

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

PRENATAL DENTAL

LMP

EDC

APPOINTMENT

CHCCMO PROVIDER HOSPITAL

PREVIOUS CHCCMO PROVIDER HOSPITAL PREFERENCE