



PEDS MEDICAL/DENTAL

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: / /	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 <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.					
Family Size					
1	\$0 - \$13590	\$13591-\$20385	\$13592-\$23783	\$23784-\$27180	\$27181 and up
2	\$0 - \$18310	\$18311-\$27465	\$27466-\$32043	\$32044-\$36620	\$36621 and up
3	\$0 - \$23030	\$23031-\$34545	\$34546-\$40303	\$40304-\$46060	\$46061 and up
4	\$0 - \$27750	\$27751-\$41625	\$41626-\$48563	\$48564-\$55500	\$55500 and up
5	\$0 - \$32470	\$32471-\$48705	\$48706-\$56823	\$56824-\$64940	\$64941 and up
6	\$0 - \$37190	\$37191-\$55785	\$55786-\$65083	\$65084-\$74380	\$74381 and up
7	\$0 - \$41910	\$41911-\$62865	\$62866-\$73343	\$73344-\$83820	\$83821 and up
8	\$0 - \$46630	\$46631-\$69945	\$69946-\$81603	\$81604-\$93260	\$93261 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:
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# 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.***

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**PATIENT, PARENT OR LEGAL GUARDIAN SIGNATURE**

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

The following form is designed for those situations where minors or wards are unaccompanied by either parents or legal guardians. This consent gives authority for up to 5 designated adults to arrange for care for a minor or ward in the event of a parent or legal guardian's absence or emergency. This is extremely important, in that care cannot be provided to a minor or ward without approval by the parents or legal guardians, unless there is a written consent authorizing another adult to give approval. This authorization will remain in effect until further written notice. In the event an adult not listed below brings the minor or ward in for care without proper documentation, we will be required to reschedule the appointment.

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*Minor's/Ward's Full Name*

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*Minor's/Ward's Address*

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*City, State, Zip Code*

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*Minor's/Ward's Birth Date*

The parent/guardian does hereby authorize:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

to consent to any treatment for the above named minor/ward which is deemed advisable by and to be rendered under the supervision of a CHCCMO provider.

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*Parent or Guardian Signature*

*Date*

---

*Parent or Guardian (please print)*

*Date*

---

*Witness*

*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:** \_\_\_\_\_



1511 Christy Drive  
Jefferson City, MO 65101  
Phone (573) 632-2777  
Fax (573) 644-7924

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## Informed Consent for Local Anesthetics

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**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



1511 Christy Drive Jefferson  
City, MO 65101  
Phone (573) 632-2777  
Fax (573) 644-7924

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## Informed Consent for General Dental Procedures

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**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

# 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: \_\_\_\_\_