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:		
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? ☐ Yes ☐ No
If yes, please further specify (circle one):
Mexican/Mexican American/ Chicano/ Puerto Rican
Cuban/ Other Hispanic or Latino Origin

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 ☐ Legal 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.*

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	☐ Refuse to report - please initial _____				
1	$0 - $15060	$15061-$22590	$22591-$26355	$26356-$30120	$30121 and up
2	$0 - $20440	$20441-$30660	$30661-$35770	$35771-$40880	$40881 and up
3	$0 - $25820	$25821-$38730	$38731-$45185	$45186-$51640	$51641 and up
4	$0 - $31200	$31201-$46800	$46801-$54600	$54601-$62400	$62401 and up
5	$0 - $36580	$36581-$54870	$54871-$64015	$64016-$73160	$73161 and up
6	$0 - $41960	$41961-$62940	$62941-$73430	$73431-$83920	$83921 and up
7	$0 - $47340	$47341-$71010	$71011-$82845	$82846-$94680	$94681 and up
8	$0 - $52720	$52721-$79080	$79081-$92260	$92261-$105440	$105441 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:

Patient Name: _____ DOB: _____

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 for an appointment 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.

FAMILY PRACTICE/PEDIATRICS/OBGYN/MENTAL HEALTH
In the event of excessive missed appointments, CHCCMO has the right to grant care on an emergency or walk in basis only.

DENTAL
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.

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

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

Patient Name: _____ DOB: _____

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: _____

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*.

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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

Patient Name: _____

COMMUNITY HEALTH CENTER OF CENTRAL MISSOURI
OB PATIENT MEDICAL HISTORY FORM

MEDICATIONS (*Please list all current medications, vitamins and herbal supplements. Also list any medications you have taken during your pregnancy even if discontinued.)*

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

Allergy to latex ❑ No ❑ Yes

SCREENING HISTORY

Screening Test	Date Last Performed	Results
PAP Smear		
Mammogram		
Cholesterol		
Diabetes Testing		
STD Screening		

MENSTRUAL HISTORY

First day of your last period: ____/____/_____❑ Definite Date ❑ Approximate Date ❑ Date Unknown

Menses ❑ Regular ❑ Irregular

On contraception at time of conception? ❑ No ❑ Yes – What kind? _____

Date of first positive pregnancy test ____/____/_____

PREGNANCY HISTORY (*If you have never been pregnant please skip this section.*)

Total number of pregnancies (including this one) _____

Tubal/Ectopic Pregnancies _____

Number of deliveries _____

Miscarriages _____

Abortions _____

Number of living children _____

Number of premature deliveries _____

Patient Name: _____

Children:

Gender	Date of Birth	Name	Approx. Wks Born At	Birth Weight	Delivery Type (Vaginal or C-section)	Anesthesia	Complications	Place of Delivery	Provider Name

Do all of you children current live with you? ❑ Yes ❑ No – Please explain: _____

_____

CURRENT PREGNANCY

Was this a planned pregnancy? ❑ No ❑ Yes

Is this your first prenatal visit for this pregnancy? ❑ No ❑ Yes

If no, please indicate where care was received prior to today: _____

Father of Baby Name: _____

Is he aware of this pregnancy? ❑ Yes ❑ No Does he plan to be involved? ❑ Yes ❑ No Do you need info on paternity testing? ❑ Yes ❑ No

HISTORY IMPORTANT TO PREGNANCY (*Please check all that apply to you.)*

Medical:

❑ Diabetes – any kind
❑ High blood pressure
❑ Heart disease or heart defect
❑ Autoimmune disorder (lupus, multiple sclerosis, rheumatoid arthritis)
❑ Kidney disease/recurrent UTI
❑ Neurologic/epilepsy/seizures
❑ Psychiatric or mental health
❑ Hepatitis/liver disease
❑ Thyroid problems
❑ Trauma/violence
❑ Physical/sexual abuse
❑ History of blood transfusions
❑ D(Rh) sensitized
❑ Pulmonary (TB, Asthma)
❑ Breast
❑ GYN surgery
❑ Operations/hospitalizations
❑ Anesthetic complications
❑ Abnormal PAP smear
❑ Uterine malformation
❑ Infertility
❑ Cervical procedures – D&C, LEEP, conization, cryotherapy or cauterization, cerclage
❑ Other: _____

Infection:

❑ Live with someone with TB or exposed to TB
❑ Yourself or partner have genital herpes
❑ Rash or viral illness since last period
❑ Hepatitis B
❑ Hepatitis C
❑ Sexually transmitted infection
❑ HPV
❑ Gonorrhea
❑ HIV
❑ Chlamydia
❑ Syphilis
❑ Genital warts
❑ Have more than one recent sexual partner
❑ Prostitution
❑ Have sex with men who have sex with other ment
❑ Previous baby or pregnancy complicated by group B strep
❑ Chicken Pox
❑ Eat more than 2 servings of fish per week
❑ Other: _____

Patient Name: _____

OTHER PERSONAL MEDICAL HISTORY (*Please indicate any other **current/prior** medical problems that apply to you.*)

❑ Anemia
❑ Cancer: _____
❑ Clotting disorder
❑ High cholesterol
❑ Endometriosis
❑ Fibroid uterus
❑ Gallbladder disease
❑ Sickle Cell
❑ Incompetent cervix
❑ Pelvic inflammatory disease/infection
❑ Polycystic ovaries
❑ Pulmonary embolism
❑ Recurrent vaginal infections

SURGICAL HISTORY (*Please list **ALL** past surgeries)*

Procedure/Surgery	Date

GENERAL QUESTIONS

If needed, do you consent to receive a transfusion? ❑ Yes ❑ No
Are you interested in having your tubes tied, tubal ligation after the baby is born? ❑ Yes ❑ No
Do you plan to ❑ Breastfeed ❑ Bottle Feed ❑ Both
Do you have cats in the home? ❑ Yes ❑ No
Do you use a seatbelt? ❑ Yes ❑ No

FAMILY HISTORY (*Please indicate any that apply to your **immediate family** and which member is/was affected.*)

Alcoholism _____
Asthma _____
Autoimmune disorder _____
Cancer (indicate kind) _____
Cardiovascular disease _____
Bleeding disorders _____
Coronary artery disease _____
Depression _____
Developmental delay _____
Diabetes _____
High cholesterol _____
High blood pressure _____
Mental illness _____
Kidney disease _____
Seizures/Epilepsy _____
Spina bifida _____
Stroke _____
Thyroid Disease _____
Other: _____

SOCIAL HISTORY

Tobacco Use (Check One) ☐ Ex-Smoker ☐ Never Used ☐ Current Use ☐ Chewing
Alcohol Use ❑ No ❑ Yes - Frequency ❑ Daily ❑Weekly ❑ Monthly ❑ Occasionally ❑ Rarely
Caffeine Intake ❑ 1-2 drinks/day ❑ 3 or more drinks/day
Recreational Drug Use ❑ No ❑ Yes - ❑ Marijuana ❑ Methamphetamine ❑ Cocaine ❑ Heroin ❑ Opiates
❑ Other: _____
Exercise ❑ 1-2 times/week ❑ 3 or more times per week ❑ None ❑ Sporadic

GENETIC SCREENING (*Please check any below that applies to yourself, the baby's father, or anyone in either family.)*

❑ Yes ❑ No	Patient's age is 35 years or older
❑ Patient ❑ Baby's Father ❑ Relative	Italian, Greek, Mediterranean or Asian Background
❑ Patient ❑ Baby's Father ❑ Relative	Neural defect (meningomyelocele, spina bifida or anencephaly
❑ Patient ❑ Baby's Father ❑ Relative	Congenital heart defect
❑ Patient ❑ Baby's Father ❑ Relative	Down syndrome-
❑ Patient ❑ Baby's Father ❑ Relative	Tay-sachs (Jewish, Cajun, French Canadian)
❑ Patient ❑ Baby's Father ❑ Relative	Canavan disease (Jewish)

Patient Name: _____

❑ Patient ❑ Baby's Father ❑ Relative	Familial dysautonomia (Jewish)
❑ Patient ❑ Baby's Father ❑ Relative	Sickle cell disease or trait
❑ Patient ❑ Baby's Father ❑ Relative	Hemophilia or other blood disorders
❑ Patient ❑ Baby's Father ❑ Relative	Muscular dystrophy
❑ Patient ❑ Baby's Father ❑ Relative	Cystic fibrosis
❑ Patient ❑ Baby's Father ❑ Relative	Huntington's chorea
❑ Patient ❑ Baby's Father ❑ Relative	Mental retardation/autism
❑ Patient ❑ Baby's Father ❑ Relative	Other inherited genetic or chromosomal disorder
❑ Patient ❑ Baby's Father ❑ Relative	Maternal metabolic disorder (Type 1 diabetes, PKU)
❑ Patient ❑ Baby's Father	Patient or baby's father had child with birth defect not listed above
❑ Patient ❑ Baby's Father ❑ Relative	Recurrent pregnancy loss or stillbirth

ADDITIONAL CONCERNS

❑ Yes ❑ No Are you interested in Down Syndrome or chromosomal abnormality screening for your baby?
❑ Yes ❑ No Are you interested in spine defect or Spina Bifida screening for your baby?
❑ Yes ❑ No Are you interested in Cystic Fibrosis screening?
❑ Yes ❑ No Do you want more information on breast feeding?
❑ Yes ❑ No Do you need a breast pump?
❑ Yes ❑ No Do you have a social or case worker that helps with your family?– If Yes name and contact info: _____

❑ Yes ❑ No Are you interested in talking with a social worker?
❑ Yes ❑ No Are you interested in talking to a mental health counselor?
❑ Yes ❑ No Are you interested in a Drug Rehabilitation Program?
❑ Yes ❑ No Are you interested in adoption?
❑ Yes ❑ No Are you interested in terminating this pregnancy?
❑ Yes ❑ No Are you interested in seeing our dentist?

Patient Signature: _____ ***Date:*** _____

(Do not write in this section)

PRENATAL DENTAL	LMP	EDC	APPOINTMENT	PROVIDER
_____	_____	_____	_____	_____

PREVIOUS CHCCMO PROVIDER	HOSPITAL	HOSPITAL PREFERENCE
_____	_____	_____