Pediatric Packet

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

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.

Note: This form does not replace the need for a HIPAA Agreement. You will need to separately indicate the below individuals on the HIPAA form to grant authorization for them to have access to the individual's healthcare information and discuss care, treatment, payment, or appointments.

_____

Minor's/Ward's Full Name

_____

Minor's/Ward's Address

_____

City, State, Zip Code

_____

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.

_____

Parent or Guardian Signature *Date*

_____

Parent or Guardian (please print) *Date*

_____

Witness *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: _____ DOB: _____

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

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 risks of the procedure, alternative treatments, or the option of no treatment.

Ask: Do I understand the procedure, do I have another choice?

When you consent you are acknowledging your willingness to accept known risks and complications.

Ask: What will happen if I don't do this procedure?

Heart conditions, pregnancy, stroke, joint replacements, and other medical conditions can create a risk of complications. Please report all health conditions and medications accurately to reduce chances of complications.

Ask: Have I told the dentist all my medical problems?

General dental procedures include examination, dental prophylaxis, fluoride treatment, xrays, restorations, periodontal therapy, pulp therapy, stainless steel crowns, extractions, crowns, bridges, endodontic therapy, removable appliances like dentures and partial dentures, minor surgical procedures like fiberotomy, frenelectomy.

There are no guarantees of ultimate outcomes of any procedure, but the risks and benefits have been explained.

Ask: Why am I signing a general consent form?

This form is a general explanation of procedures offered, and your agreement to these procedures. Some procedures needed added consent like extraction of teeth and root canals.

INFORMED CONSENT FOR LOCAL ANESTHETICS

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:

- Dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, allergic reaction.
- Stiff or sore jaw muscles at injection site.
- Prolonged numbness, and risk of biting lip, tongue, or cheek, causing injury.
- Injury to the nerves causing pain, numbness, tingling, especially in chin, lip, cheek, gums,or tongue. Usually lasts 24 hours or less.
- Breaking needle in mouth requires removal by a specialist.
- Large bruise at injection site causing swelling, stiff muscles, opening and closing 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, PARENT, OR LEGAL GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT DATE

WITNESS 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)

			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: _____