

**COMC** Central Ozarks  
Medical Center  
Medical • Behavioral • Dental  
**NEW PATIENT REGISTRATION FORM**

Patient Name (Please Print): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Birth Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Do you have an Advance Directive? \_\_\_ Yes \_\_\_ No If yes, please provide COMC a copy.

**Responsible/Insured Party Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Social Security Number: \_\_\_\_\_

**Assignment of Benefits and Authorization to Release Medical Information**

I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to me or on my behalf to the provider listed on this form, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the division of Family Services, the Health Care Financing Administration, listed insurer (s), and/or agents of these companies, and/or the listed responsible person(s), any information needed to determine these benefits or the benefits for other related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I have been made aware of the Sliding Fee Discount Program offered by Central Ozarks Medical and Dental Centers. I would like to **Apply** \_\_\_\_\_ or **Not Apply** \_\_\_\_\_. If you choose apply, forms to do so will be provided by Reception Staff. If you have not been informed of this program please ask Reception Staff for details.*

*If you are enrolled in Medicare, please provide HIC number and sign below*

I request payment of authorized Medical benefits be made to Central Ozarks Medical Center, and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

HIC Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No **If yes, please list physician's name and name of the medical clinic:**  
\_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No **If yes,** \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No **If yes,** \_\_\_\_\_
- Have you ever had any abnormal bleeding, associated with previous extractions or surgery?  Yes  No **If yes,** \_\_\_\_\_
- Are you taking any medication, pills or drugs?  Yes  No **If yes, please note on the following page.**
- Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medications containing bisphosphonates?  
 Yes  No **If yes,** \_\_\_\_\_
- Do you use controlled substances?  Yes  No **if yes,** \_\_\_\_\_
- Do you use tobacco?  Yes  No

**Do you have, or have you had, any of the following?**

Aids/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	COPD <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's <input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Autism/Cognitive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting /Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No	Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other serious illness not listed?		Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No

**All Patients: Are you allergic to any of the following?**

- Aspirin                       Penicillin                       Codeine                       Acrylic                       Metal                       Latex                       Sulfa Drugs  
 Local Anesthetics                       Nut Allergy                       Milk Protein                       Tylenol                       Ibuprofen/NSAIDS  
 Other? \_\_\_\_\_





Central Ozarks  
Medical Center

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Date: \_\_\_\_\_

I hereby authorize the below listed individuals access to my health information (if this section is not completed, we will only use your medical record for treatment, payment and healthcare purposes. We will not be able to release your medical information to family members or friends unless they are listed by name below):

<u>Individual</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Signature of the Patient, Guardian, or Power of Attorney:

\_\_\_\_\_  
If not the patient; please note if you are the Guardian or Power of Attorney:

\_\_\_\_\_  
Witness Signature:

# COMC Dental

304 W. Washington, Richland, MO 65556

## Informed Patient Consent

I hereby give permission for the following treatment to be performed on me as a patient of Central Ozarks Medical Center Dental Clinic.

- Examination and/or X-Rays
- Restorative and/or Prosthetics (fillings, crowns, dentures)
- Prophylaxis (cleaning)
- Endodontic (root canal therapy)
- Oral surgery
- Periodontal (gum) Therapy
- Other \_\_\_\_\_

I understand that I have the right to refuse any procedure at any time and that no guarantee regarding success or longevity of any dental procedure is implied or expressed. I also understand the possible risks\* associated with treatment and have had the opportunity to ask questions of the dental staff to my satisfaction.

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Signature of Patient, Parent or Guardian

Date

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Relationship to Patient

Date

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Witness Signature

Date

\*Possible risks include, but are not limited to: pain, swelling, infection, total or partial numbness in lips, cheeks or tongue (either permanently or temporarily) and death. Also, due to potentially fatal interaction of certain compounds, I will inform the dental staff if I have used any illegal or illicit drugs or compounds.\*


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**Consent for Treatment of a Minor**

I, \_\_\_\_\_, consent for treatment of \_\_\_\_\_.  
Printed Name of Parent/Guardian Printed Name of Minor

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. I understand that for any treatment to occur, this minor must be accompanied by the adult(s) (over the age of 18) named below.

This consent allows for treatment today and all future appointments. This record may be given to other providers within Central Ozarks Medical Center to treat this minor as needed.

\_\_\_\_\_  
 Signature of Parent/Guardian Date

Please list the names of all adults and their relationship to the minor patient who may bring this minor to appointments **and** consent for any and all recommended dental/medical services. *This authorization will remain in effect until changes are made by the parent/guardian signing this form.*

_____ Name	_____ Relationship to Minor
_____ Name	_____ Relationship to Minor
_____ Name	_____ Relationship to Minor
_____ Name	_____ Relationship to Minor

**Minor Children (Ages 16 and older)**

My child, \_\_\_\_\_ may be seen for dental attention in the office of Central Ozarks Medical Center – Richland Dental Clinic WITHOUT a parent or legal guardian present. I understand that I will be contacted for treatment plans or any changes in treatment.

Parent/Legal Guardian: \_\_\_\_\_

## Dental Clinic Appointment Policy

### **Cancellations:**

If you cannot come to a dental appointment, please call the clinic at least the day before your appointment. This helps to fill the time with someone who has been waiting for care.

### **Late Arrival:**

If you arrive more than 15 minutes late for a dental appointment or fail to come two times within a year we may not give you a dental appointment. Instead your name will be placed on the call list and you will be called for an appointment when your name comes to the top of the list. In the interim, you will be seen, only as an emergency patient.

### **Failed Appointments:**

If you cancel at the time of your appointment or fail to come two times within a year we may not give you a dental appointment. Instead your name will be placed on the call list and you will be called for an appointment when our name comes to the top of the list. In the interim, you will be seen, only as an emergency appointment.

### **Children under 16:**

We are happy to see children as patients. A parent or guardian must come with them to the clinic and remain in the clinic at all times. A signed and dated permission note by the child's guardian can be used when accompanied by a responsible adult over 18 years of age.

Children **cannot** be left alone in the waiting room or accompany patients to the treatment area, please make arrangements for someone to care for them if you have a dental appointment or need to accompany another minor child in their appointment.

If you understand and agree to this policy, please sign below.

Signature of Patient, Parent or Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

### **About Our Notice of Privacy Practices**

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices detail the following:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in this Notice.
- The person to contact for further information about our privacy practices.

To receive a copy of the Notice of Privacy Practices, please ask registration. We are required by law to obtain your written acknowledgement that you are aware of this notice and have been provided an opportunity to obtain a copy.

### **Patient Acknowledgement of Receipt**

I \_\_\_\_\_, hereby acknowledge that I have been provided an opportunity to obtain a copy of the Notice of Privacy Practices.

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Signature of the Patient, Guardian, or Power of Attorney

Date



**Please tear this page off and retain for your records**

This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 765-5131 or [cmcelyea@centralozarks.org](mailto:cmcelyea@centralozarks.org).

**Who will follow this notice?**

The list below tells you who will follow the outlined practice for keeping your medical record private. All Central Ozarks Medical Center Medical and Dental Clinics (COMC). Any COMC health care professional that treats you at any of our locations. All COMC employees, temporary or contract staff, students and volunteers.

**What is this Notice?**

We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.

**We may use and disclose your health information for:**

**Treatment:** We may use and disclose health information for your medical treatment and services. **Payment:** We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations:** We may use and disclose health information for purposes of health care operations. **Appointment Reminders:** To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law:** When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety:** To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities:** To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors:** As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities:** To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others:** To federal officials to provide protection to the President and other authorized persons, or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not



allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.

**Your rights regarding your health information:** In most cases, **you may make a written request to look at, or get a copy of your health information.** If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information.** You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information,** for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner.** You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. **You may request, in writing, that we not use or disclose your health information** for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**

#### **Complaints:**

If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Courtney McElyea, at 573-765-5131 or by email at [cmceleya@centralozarks.org](mailto:cmceleya@centralozarks.org). You may write us at Central Ozarks Medical Center Attn: Courtney McElyea PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: 1-573-751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html> The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at <http://www.centralozarks.org>. You may also request a paper copy of the current Notice of Privacy Practices at any time.