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Your Health.....Our Mission.

Central Ozarks Medical Center
If you need help filling out this form, please let us know.

ADULT DENTAL REGISTRATION FORM

(Please Print)

Today's Date:	COMC Medical Provider:	COMC Dental Provider:

PATIENT INFORMATION

Patient's First Name: Middle Initial: Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F
Street Address:	City:	State:	Zip Code:	
Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless Shelter ❑ Homeless ❑ Other: _____			
Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )	
May we text you for appointment reminders: ❑Yes ❑ No	Preferred Pharmacy:	Preferred method of contact for reminder calls and messages: □ Cell □ Home □ Work		
❑ Parent/Guardian **OR** ❑ Emergency Contact Name: _____ Number: _____	Address: ❑ Same as above	Primary Phone Number: ( )		

Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Primary Phone Number: ( )	
Occupation:	Employer:		Employer Phone Number: ( )	
Patients relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other				
Primary Medical Insurance:	❑ Medicare ❑ Medicaid	❑ Blue Cross Blue Shield	❑ Cigna	❑ Other:
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #:	Group #: Co-Payment: $
Name of **Secondary Medical Insurance** (if applicable):	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #: Group #:

DENTAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Dental Insurance:	Subscriber's Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /

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: _____

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Central Ozarks Medical Center. I understand that I am financially responsible for any balance. I also authorize COMC or my insurance company to release any information required to process my claims.

Signature:_____Date: _____

Circle of Care: Please list names of **ALL** providers who are treating you, including - Behavioral Health, Dentists and Specialists		
Name:	**Specialty:**	**Phone:**
1.		
2.		
3.		

Ethnicity	
	Hispanic or Latino
	Not Hispanic
	Unreported /Refused to Report Ethnicity

Race	
	Asian
	Native Hawaiian
	Other Pacific Islander
	Black/African American
	American Indian/ Alaska Native
	White (not Hispanic or Latino)
	More than one race
	Not Reported / Refuse to Report

Primary Language	
	English
	Spanish
	Russian
	Ukrainian
	Other Please Specify:

How did you hear about us?	
	Newspaper/TV/Radio Ad
	Website
	Special Event
	Employee
	Other Organization
	Friend
	Other

Do you identify yourself as:	
	Straight (not lesbian or gay)
	Lesbian or gay
	Bisexual
	Something else
	Don't know
	Chose not to disclose
	Other

Education	
	Current Student?
	Full Time
	Part Time

Highest Level of Education	
	Not yet in school
	Pre-School Kindergarten
	Grade School
	Middle School
	High School
	High School Degree/ GED
	Did not complete High School
	Technical Trade School
	College
	College Graduate

COMC is my primary medical home?	
	Yes
	No

What is your current gender identity?	
	Female
	Male
	Transgender Male Female-to-Male
	Transgender Female Male-to-Female
	Gender queer, neither exclusively male nor female
	Other
	Chose not to disclose

Employment Status	
	Full Time/ Part Time
	Migrant Worker
	Not a Migrant Worker
	Seasonal

Housing
☐Homeless
☐Doubling Up ☐Shelter ☐Other ☐Street ☐Transitional ☐Unknown
☐Public Housing-HUD
☐ Permanent Supportive Housing (PSH)

Are you a veteran?	
	Yes
	No

I am using COMC today for an urgent care need?	
	Yes
	No

What sex were you assigned at birth on your original birth certificate?	
	Female
	Male
	Chose not to disclose

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.

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Central Ozarks Medical Center
Sliding Fee Discount Schedule
Effective June 1, 2020

*****Sliding Fee Discount Program eligibility is based solely on family size and income. Please speak to a member of our staff to apply*****

OFFICE FEE PER VISIT					
Medical	$30	$40	$60	$80	Full Fee
Behavioral Health	$30	$40	$60	$80	Full Fee
Dental	$50	Greater of $75 or 30% of Charges	Greater of $75 or 40% of Charges	Greater of $75 or 50% of Charges	Full Fee
Hospital	$30	Greater of $30 or 40% of Charges	Greater of $30 or 60% of Charges	Greater of $30 or 80% of Charges	Full Fee

FEDERAL POVERTY GUIDELINES (2020)					
Family Size	Level A (0-100% PFG)	Level B (101-133% PFG)	Level C (134-166% FPG)	Level D (167-200% FPG	Level E (Above 200% FPG)
1	$0 - $ 12,760	$12,761 - $ 16,971	$16,972 - $ 21,182	$21,183 - $ 25,520	$25,521 and Above
2	$0 - $ 17,240	$17,241 - $ 22,929	$22,930 - $ 28,618	$28,619 - $ 34,480	$34,481 and Above
3	$0 - $ 21,720	$21,721 - $ 28,888	$28,889 - $ 36,055	$36,056 - $ 43,440	$43,441 and Above
4	$0 - $ 26,200	$26,201 - $ 34,846	$34,847 - $ 43,492	$43,493 - $ 52,400	$52,401 and Above
5	$0 - $ 30,680	$30,681 - $ 40,804	$40,805 - $ 50,929	$50,930 - $ 61,360	$61,361 and Above
6	$0 - $ 35,160	$35,161 - $ 46,763	$46,764 - $ 58,366	$58,367 - $ 70,320	$70,321 and Above
7	$0 - $ 39,640	$39,641 - $ 52,721	$52,722 - $ 65,802	$65,803 - $ 79,280	$79,281 and Above
8	$0 - $ 44,120	$44,121 - $ 58,680	$58,681 - $ 73,239	$73,240 - $ 88,240	$88,241 and Above
9 or more	Add $4,480 for each additional member	Add $5,958 for each additional member	Add $7,437 for each additional member	Add $8,960 for each additional member	Add $8,960 for each additional member

Revised 5/8/2020

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Patient Name: _____ **Date of Birth:** _____

- Are you under the care of a physician now? □Yes □No If yes, please list the physician's name and name of medical clinic:

_____

- Have you ever been hospitalized or had a major operation? □Yes □No If yes, please list surgeries:

_____

- Have you ever had a serious head or neck injury? □Yes □No If yes, please explain: _____
- Have you ever had any abnormal bleeding, associated with previous extractions or surgery? □Yes □No If yes, please explain: _____
- Are you taking medication, pills or drugs? □Yes □No **If yes, please list on following page.**
- Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medication containing biosphosphonates? □Yes □No If yes, please explain: _____
- Do you use controlled substances? □Yes □No If yes, please list_____
- Do you use tobacco? □Yes □No If yes, how long: _____Packs per day:_____

Do you have, or have you had any of the following diseases/conditions?

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

All patients, are you allergic to any of the following:

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

Women, are you?

Pregnant/Trying to get pregnant? □Yes □No Nursing? □Yes □No Taking oral contraceptives? □Yes □No
If pregnant, how many weeks? _____ Due Date: _____

Signature of Patient, Parent or Guardian:_____

Relationship to Patient: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I am aware that it is my responsibility to inform the dental office of any changes in medical status.

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Current Medications

Patient Name: _____ Date of Birth: _____

Please include prescription, over the counter medications and supplements/vitamins:

Medication Name	Strength	Frequency	Prescribed by:

Pharmacy of Choice: _____

Signature of Patient, Parent or Guardian: _____ **Date:**_____

Relationship to Patient: _____

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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):

Individual	**Relationship**	**Phone Number**

_____

Signature of Patient, Guardian or Power of Attorney: **Date:**

_____

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

_____

Witness Signature: **Date:**

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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.

Signature of Patient, Parent or Guardian:

_____ Date: _____

Relationship to patient:

_____ Date: _____

Witness:

_____ 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 COMC dental staff if I have used any illegal or illicit drugs or compounds.

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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 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 appointment.

Children under 16:

We are happy to see children as patients. A parent or guardian must always come with them to the clinic and remain in the clinic . 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 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: _____ **Date:** _____

Relationship to Patient:

_____

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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.

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.

Signature of Patient, Guardian, or Power of Attorney:

_____

Date:

_____

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Notice of Privacy Practices

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) 836-7112 or amcnulty@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, Amy McNulty, at 573 836-7112 or by email at amcnulty@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Amy McNulty 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: https://www.centralozarks.org. You may also request a paper copy of the current Notice of Privacy Practices at any time.