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:**_____

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Pediatric Health History for NEW Patients

Child's Name_____ Date_____
Date of Birth_____ Place of Birth_____
Parent/Guardian 1: _____
Parent/Guardian 2: _____
E-mail Address_____
Preferred Method of Communication_____

Main reason for today's visit: _____
Where was your child receiving care before? _____

PREGNANCY & BIRTH: Please fill in the following information about your pregnancy and birth history with this child, as you remember.

PREGNANCY HISTORY:
Prenatal Care: [ ] Yes [ ] No Provider: _____
Blood Type: _____ Hepatitis B: + or –
How many times pregnant? ___
How many children? ___
Miscarriage/Abortion? ___
Maternal Health Problems:
[ ] Pre-eclampsia [ ] Bleeding
[ ] Pre-Term Labor [ ] High Blood Pressure
[ ] Infections [ ] Diabetes
[ ] Abnormal U/S [ ] Rh Incompatibility
[ ] Alcohol/Drugs [ ] Tobacco/Smoking
[ ] Shoulder Dystocia [ ] Bleeding/Bruising
[ ] Infection [ ] Urine/Stool Problems
[ ] Birth defects [ ] Feeding Problems

BIRTH HISTORY:
Birth Location: [ ] Hospital [ ] Home [ ] Other
Hospital Name: _____
Due date: _____ Birth was [ ] Vaginal [ ] C-Section
Gestation: [ ] Term (37+ wks) [ ] Pre-Term (36 wks or less)
Birth Weight: _____ Birth Length: _____
Birth Head Circumference: _____
Circumcision? Y or N Hepatitis B vaccine? Y or N
Birth Problems:
[ ] Breach [ ] Forceps
[ ] Nuchal Cord [ ] Low APGARs
[ ] Jaundice [ ] Breathing Problems

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know that you wrote there.
□**MY CHILD TAKES NO MEDICATIONS** Please list your pharmacy of choice:_____

MEDICATION	DOSE (MG/PILL)	HOW MANY TIMES PER DAY

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ALLERGIES: Please list all allergies or intolerance to medications. Please include type of reaction:

□**NO KNOWN DRUG ALLERGIES**

ALLERGIES	TYPE OF REACTION

REVIEW OF SYMPTOMS: Please mark the box for any **persistent** symptoms your child has had in the **past few weeks**. Read through every section and check "no problems" if none of the symptoms apply to your child. List other concerns above.

General:
__Fever/Chills
__Night sweats
__Unexplained weakness
__Excessive Fatigue
__Decreased activity
__ Unexplained weight loss/gain
__**NO PROBLEMS**

Eye
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__**NO PROBLEMS**

Ear/Nose/Throat
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear Pain
__Dental cavities
__**NO PROBLEMS**

Respiratory:
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath with exercise
__**NO PROBLEMS**

Cardiovascular
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__**NO PROBLEMS**

Gastrointestinal
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__**NO PROBLEMS**

Genitourinary:
__Urinating more often
__Wetting the bed at night
__**NO PROBLEMS**

Musculoskeletal
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__**NO PROBLEMS**

Hematologic/Lymphatic
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__**NO PROBLEMS**

Skin:
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__**NO PROBLEMS**

Neurological:
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__**NO PROBLEMS**

Psychiatric
__Anxiety/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__**NO PROBLEMS**

Endocrine:
__Heat Sensitivity
__Cold Sensitivity
__Excessive Thirst
__Excessive Hunger
__High/Low blood sugar
__**NO PROBLEMS**

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PERSONAL MEDICAL/SURGICAL HISTORY: Does your child have now (current) or had in the past any of the following conditions?

√	Condition	Comments	√	Condition	Comments
	Alcohol/Drug Abuse			EGD (Stomach Endoscopy)	
	Allergy/Hay Fever			Fractures (broken bones)	
	Anemia			Heartburn/reflux (GERD)	
	Anxiety			Heart Condition	
	Arthritis (Juvenile, Psoriatic, Other)			Heart Surgery	
	Appendectomy (appendix removal)			Hepatitis – Type A/Type B/Type C	
	Asthma			Hernia Repair	
	Bipolar Disorder			High Blood Pressure	
	Blood Transfusion			High Cholestoral	
	Cancer – Leukemia			Inflammatory Bowel Disease	
	Cancer (Other type) _____			Irritable Bowel Syndrome	
	Colonoscopy/Sigmoidoscopy			Kidney Disease/Failure	
	Depression			Kidney Stones	
	Diabetes (Adult Onset) (Type2)			Liver Disease	
	Diabetes (Childhood Onset) (Type1)			Lupus	
	Migraine/Tension Headaches			UTI	
	Pneumonia			Other (list)	
	Seizures/Epilepsy			Other (list)	
	Skin Condition (Eczema/Psoriasis)			Other (list)	
	Sleep Apnea			Other (list)	
	Overactive thyroid/hyperthyroidism			Other (list)	
	Low thyroid/hypothyroidism			Other (list)	

PERSONAL MEDICAL/SURGICAL HISTORY: Please indicate which relative has had the following diseases (parents and sibling are the most important).

ADOPTED? YES or NO (please circle) if yes and you do **not** know your child's family history, you may skip this section.

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√	DISEASE	RELATIONSHIP (Father, Mother, Children, Grandparents, Aunt/Uncles Other)	COMMENTS
	No significant history known		
	Alcoholism/Drug abuse		
	Alzheimer's Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer _____		
	Cancer _____		
	Coronary Artery Disease (Heart attack, Angina)		Age of Onset:_____
	Depression/Suicide/Anxiety		
	Diabetes – Type 1 (childhood onset)		
	Diabetes – Type 2 (adult onset)		
	Emphysema (COPD)		
	Genetic Disorder (explain)		
	Heart Failure (CHF)		
	Hepatitis (A, B, or C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine Headaches		
	Osteoporosis		
	Stroke		
	Other (please list)		

SOCIAL HISTORY:

Home Environment:

Who lives at home with your child?

_____
_____
_____

Please list siblings and ages:

_____
_____
_____
_____

Problems or Stress at Home?

_____
_____

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Growth/Development:
Do you think your child is growing and developing normally? { } Yes { } No

Do you have any concerns about your child's growth?

_____
_____

Do you have any concerns about your child's development?

_____
_____

Education:
Grade in School: ____ School Name: _____
Teacher's Name: _____
Does your child do well in school? { } Yes { } No
Does your child enjoy school? { } Yes { } No
Is your child concerned about bullying? { } Yes { } No
Is your child concerned about safety? { } Yes { } No

Health Maintenance Screening Tests:
{ } Newborn Screening
{ } Lead Screening
{ } Anemia (Hgb/Hct) Screening
{ } Cholesterol Screening
{ } Autism screening (18 months of age)
{ } Dentist. Last Visit_____
{ } Eye doctor. Last Visit: _____

Activity:
Estimated hours of physical activity or active playtime your child engages in each week: _____

Estimated hours of TV, video games, or computer time your child engages in each week: _____

Sport or School activities? _____

Family activities? _____

Diet:
For infants: { } Breastfeeding { } Formula_____
Balanced Diet? { } Yes { } No_____
Food Allergies? { } Yes { } No_____
Special Diet? { } Yes { } No_____
Do you have any concerns about your child's nutrition?

_____
_____
_____

Safety:
Type of car seat: { } Rear-facing { } Forward Facing

Do you use your car seats or seatbelts consistently?
{ } Yes { } No

Do you have your child use a bike helmet?
{ } Yes { } No

Home has a working smoke detector?
{ } Yes { } No

Is violence at home a concern for you?
{ } Yes { } No

Tobacco/Alcohol/Drug Exposure:
Is your child exposed to any of the following at home, school or other location?
Tobacco: { } Yes { } No
Alcohol: { } Yes { } No
Drugs: { } Yes { } No
Are prescription medications kept locked and away from your child at home? { } Yes { } No

Thank you for taking the time to fill out this important health documentation.

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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 accompany this minor to appointments:

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

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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 the Patient, Guardian, or Power of Attorney:

_____

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

_____

Witness Signature:

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Consent to Obtain External Prescription History

I, _____, authorize Central Ozarks Medical Center to view my prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Central Ozarks Medical Center, and may contain prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE ACCESS.

_____ _____

Patient Signature Date

_____ _____

Witness Date

I **do not** consent for Central Ozarks Medical Center or its Affiliated Providers to access my external prescription history.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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Consent for Patient Portal

The patient portal allows for electronic access to view personal medical history, update personal information and ensure patient information is correct and complete. **The portal is not to be used to communicate urgent or emergency issues.**

_____

Patient Name

_____

Date of Birth

_____

Signature of Patient or Guardian

_____

If signed by Guardian state relationship to patient

_____

Email Address

_____

Date

Patient Demographics

Please fill out the information below for **your household**. Household size is defined as all people living in your home EXCEPT for those you are not financially responsible for. Marital Status is not a factor in determining household. Your information will be kept confidential.

Household Members												
			Race					Ethnicity				
Name	**Date of Birth**	**Primary Language**	White	Native Hawaiian/Pacific Islander	Black/African American	Asian	American Indian/Alaska Native	**Hispanic/Latino**	**Homeless**	**Veteran**	**COMC Patient**
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No
		□English □Other	□	□	□	□	□	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Please mark the income range for the appropriate Household size.

Income Table				
Household Size	**Income**	**Income**	**Income**	**Income**
1	□ $0 - $12,140	□ $12,141 - $16,146	□ $16,147 - $20,152	□Over $24,281
2	□ $0 - $16,460	□ $16,461 – $27,637	□ $21,893 - $27,324	□ Over $32,921
3	□ $0 - $20,780	□ $20,781 - $26,812	□ $27,638 - $34,495	□ Over $41,561
4	□ $0 - $25,100	□ $25,101 - $33,383	□ $33,384 - $41,666	□ Over $50,201
5	□ $0 - $29,420	□ $29,421- $39,129	□ $39,130 – $48,837	□ Over $58,841
6	□ $0 - $33,740	□ $33,741- $44,874	□ $44,875 – $56,008	□ Over $67,481
7	□ $0 - $38,060	□ $38,061 - $50,620	□ $50,621 - $63,180	□ Over $76,121
8	□ $0 - $42,380	□ $42,381 - $56,365	□ $56,366 - $70,351	□ Over $84,760

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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.
- 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.

_____

Signature of the 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) 765-5131 or 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 cmcelyea@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.