REGISTRATION FORM - PEDIATRIC

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Legal Last Name:	First:	Middle:

Previous Names Used/Alias:	Birth Date: / /	Age:	Social Security #:	Sex at Birth: ❑M ❑F ❑Other

Mailing Address:	City:	State:	Zip:

Parent 1 Name:	Cell Phone:	Work Phone:
Parent 2 Name:	Cell Phone:	Work Phone:

Parent 1 E-Mail Address:	Parent 2 E-Mail Address:

Best way to contact for results, follow up, or scheduling? (check all that apply)
❑ Parent 1 Cell ❑ Parent 1 Work ❑ Parent 2 Cell ❑Parent 2 Work ❑ Parent 1 Email ❑ Parent 2 Email

Child's Race:
❑Alaska Native
❑Pacific Islander
❑Native Hawaiian
❑Asian
❑White
❑American Indian
❑Black or African American
❑Unknown
❑Choose not to disclose

Child's Ethnicity:
❑Hispanic ❑Not Hispanic
❑Unknown ❑Choose not to disclose

Child's Sexual Orientation:
❑ Lesbian or gay
❑ Straight (not lesbian or gay)
❑ Bisexual
❑ Something else_____
❑ Don't know
❑ Choose not to disclose

Child's Gender Identity:
❑ Female
❑ Male
❑ Transgender Female / Male-to-Female
❑ Transgender Male / Female-to-Male
❑ Other: _____
❑ Choose not to disclose

Preferred Pronoun:
❑ she/her/hers
❑ he/him/his
❑ they/them/theirs
❑ patient's name
❑ decline to answer
❑ unknown

Family's Homeless Status:
❑Not Homeless
❑At Risk for Homeless
❑Transitional Housing
❑Living with Others
❑Homeless, Unknown Shelter
❑Living in Shelter
❑Street, Camp, Bridge
❑Currently Not Homeless, Was in the Last 12 Months

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone Number: ❑Home ❑Mobile ❑Work	Ok to leave voicemail: ❑Yes ❑No

PARENT EMPLOYMENT STATUS

Farm Work Recognition: Are you or someone in your household involved in a type of farm work that may include: soil prepping, planting, picking, cleaning, sorting, packing, Christmas tree farming?
❑Yes ❑No
❑ Migrant – You or a member of your household has established a temporary home to do farm work
❑ Seasonal – You or a member of your household do farm work that only happens at certain times of year

Is either parent a Veteran?
❑Yes ❑No

Number of Family Members:	Monthly Income (before taxes) $

LANGUAGE

What language do you speak at your home: ❑English ❑Spanish ❑Other: _____	Interpreter Needed: ❑Yes ❑No Preferred: ❑Male ❑Female ❑No Preference

(turn page over to finish reading and sign this registration form)

RESPONSIBLE PARTY If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor			
Parent/Legal Guardian Responsible for Bill:	**Birth Date:** **/ /**	**Social Security # of Parent/Legal Guardian:**	
Mailing Address: ❑ Same as above	**City:**	**State:**	**Zip:**
Phone Number:	❑Home ❑Mobile ❑Work		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neighborhood Health Center or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

FOR OFFICE USE ONLY

Initials for Special Confidentiality:_____ Screen By: _____ Total Income: $ _____

TITLE X: Clients pay _____ % per sliding fee scale for non-FPEP covered service.

Address Verification: □ Yes Date/Initials_____ □ Patient declined confidentiality

COMBINED CONSENT FORM

Patient Name _____ *Patient Date of Birth (DOB)* _____

TREATMENT AND FINANCIAL

I authorize treatment of the person named above and accept financial responsibility for all treatment, including any necessary or recommended vaccines provided. I authorize Neighborhood Health Center to provide to my insurance companies all information necessary to process insurance claims and assign Neighborhood Health Center all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy or scanned image of this authorization shall be considered as valid as the original.

ACKNOWLEDGMENT OF HIPAA NOTICE

I acknowledge receipt of Neighborhood Health Center's Notice of Privacy Practices.

PATIENT CENTERED PRIMARY CARE HOME CONSENT

Your primary care home will; better coordinate our care to help get you the services you need, listen to your concerns and answer your questions, offer after-hours help and alternatives to the emergency room, help you play an active role in your health. I have read and understand the information on Patient Centered Primary Care Home and consent to be a part of the Neighborhood Health Center Medical Home.

REPRODUCTIVE HEALTH SERVICES

When seeking reproductive health services from Neighborhood Health Center I understand that I am receiving these services voluntarily.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);

(turn page over to finish reading and sign this consent form)

- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

I understand that I won't be refused care if I owe money from other visits.

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records. Neighborhood Health Center is required by law to give the records to the court.
- If I have reportable disease, Neighborhood Health Center will be required to report it to Oregon State Public Health.
- The State of Oregon requires all Neighborhood Health Center Staff to report any abuse of vulnerable individuals, which includes children, elders, persons who are mentally ill, developmentally disabled, or living in a long term care facility to The Department of Human Services that is witnessed or learned of inside or outside of a Neighborhood Health Center Clinic.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sex partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Neighborhood Health Center.

DENTAL SERVICES

I understand that Neighborhood Health Center partners with different academic institutions and that I may be treated by a student/extern practicing under the direct supervision of a licensed professional at Neighborhood Health Center. I authorize Neighborhood Health Center professionals and their partners to provide such treatment and this authorization shall remain in effect until revoked in writing.

Patient Signature	***Date***
Signature of Patient's Representative *(If patient is under 18)*	***Date***
Relationship of Representative	

COMMUNICATION PERMISSIONS FOR PROTECTED HEALTH INFORMATION (PHI)

Patients who are minors (under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by NHC staff.

Patient Name:	**Date of Birth:**

IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU? *(please check all that apply)*:

1. Can we send bills to your address? ❑ Yes ❑ No
2. Can we send automated appointment reminders? ❑ Yes ❑ No
   If yes, which type? ❑ Phone call ❑ Text message
3. Can we call you regarding your visit/treatment with us? Types of calls that could be made:
   - Primary Care (lab Results, medical instructions, referrals, medications, etc.) ❑ Yes ❑ No
   - Dental Care ❑ Yes ❑ No
   - Behavioral Health (follow up on concerns, referrals, etc) ❑ Yes ❑ No
   - Reproductive Health (sexual health, STI treatment, test results) ❑ Yes ❑ No

Preferred Communication: ❑ Do not contact ❑ Mail ❑ Phone ❑email via MyChart ❑ No preference

If the answer to any of the above is No, how may we reach you regarding your critical healthcare?

Name of contact:

Phone number:

If you sign up for MyChart, all your information is available online. Ask the receptionist to help you sign up for MyChart

WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? & EMERGENCY CONTACTS *(NOTE: this is not an authorization to release records):*

I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: ❑ Not Applicable

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other:

Name: _____

Relationship: _____ **Phone:** _____

❑ Use this person as an emergency contact ❑ Authorized to sign on behalf of guardian in guardian's absence

Regarding *(please check all that apply)*:
❑ Schedule / cancel appointment ❑ Medical instruction / advice
❑ Prescription drug information ❑ Lab results ❑ Imaging results
❑ **All** information ❑ Other: _____

PLEASE LIST LEGAL REPRESENTATIVE, GUARDIAN, POWER OF ATTORNEY, ETC. IF ANY *(please provide proof)*

Name: _____ ❑ Not Applicable

Relationship: _____ **Phone:** _____

Name: _____

Relationship: _____ **Phone:** _____

SIGNATURE REQUIRED *(below):*

The authorization may be changed or revoked in writing at any time. It will remain in effect until one (1) year from the date below. By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature (Patient/Legal Guardian)	***Date***
Print Name	***Relationship***

INCOME VERIFICATION FORM

Patients who would like to apply for the sliding fee discount must declare their interest at the time of their visit. They must also fill out an income verification form and provide proof of gross income (income before taxes) as described below. Patients in our Title X program are exempt from this requirement.

Income is verified once a year. If a patient has a change in their income, it is their responsibility to notify Neighborhood Health Center Clinic of that change.

(*) Patients are required to give at least one of the following items as verification of income:

1. Previous year completed tax return
2. Previous year W-2
3. 2 most recent pay stubs
4. Letter from employer
5. Check stubs from Unemployment Insurance
6. Previous 3 months bank statements
7. Self-employed individuals must provide their prior year tax return and most recent 3 months of income

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

Eligibility for the sliding fee scale is based on total household income. Please list all family members within this household and combine their monthly income for the sliding scale discount.

Family Member : _____ Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Family Member :_____Date of Birth:_____

Number of Family Members: _____ Combined Monthly Payroll Amount $ _____

Payroll Frequency: _____ Weekly_____ Bi-Weekly _____ Semi-Monthly _____ Monthly

Signature of Patient or Personal Representative: _____**Date:** _____

2018 FEDERAL POVERTY GUIDELINES	
Family Size	**Monthly Income 200% or Less**
1	$2,023.00
2	$2,743.00
3	$3,463.00
4	$4,183.00
5	$4,903.00
6	$5,623.00
7	$6,343.00
8	$7,063.00

OFFICE USE ONLY

Household Monthly Income According to Documentation $ _____

Documentation Type: _____

Reviewed By: _____

Date _____

Family units more than 8 members, add $720.00 for each additional member

Patient Name: _____

DENTAL HISTORY

1. Is this your first visit to a dentist? ..... YES NO
2. Do you have dental pain, bleeding gums or sensitive teeth? ..... YES NO
3. Have you ever had an injury to your face or jaw or do you have jaw pain? ..... YES NO
4. Have you ever had any problems associated with dental treatment..... YES NO
5. Do you brush and floss your teeth and mouth daily? ..... YES NO
6. Do you currently, or have you ever used tobacco products? ..... YES NO
   If yes, explain_____
7. Do you use fluoride tablets or rinses? ..... YES NO
8. What type of dental treatment do you feel you need? _____

MEDICAL HISTORY

The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.

1. Are you receiving any type of medical treatment or have you been hospitalized? ..... YES NO
2. Have you had a recent illness or surgery? ..... YES NO
3. Are you taking any prescription, non-prescription or herbal medications..... YES NO
   If yes, list them_____
   _____
4. Are you allergic to any medications or to latex? ..... YES NO
   If yes, list them _____
5. Have you ever had excessive bleeding requiring medical treatment? ..... YES NO
6. If female, are you pregnant? YES NO. If yes, when are you due? _____
7. List your medical provider's name and phone number _____

8. Indicate which of the following you have had or have at present. Please circle.

AIDS or HIV Positive	Chest Pain/Angina	Heart Disease/Surgery	Psychiatric Treatment
Alcohol/Drug Dependency	Congenital Heart Defect	Heart Murmur	Sexually Transmitted Disease
Allergies or Hives	Diabetes	Hepatitis/Liver Disease	Sickle Cell Disease
Arthritis	ED Drug Therapy	High Blood Pressure	Sinus Problems
Artificial Joints	Endocarditis	Kidney Disease	Steroid Medications
Asthma	Epilepsy/Seizures	Nervousness	Stroke
Bisphosphonate Drugs	Fainting/Dizziness	Organ Transplant	Tuberculosis
Blood Transfusions	Glaucoma	Osteoporosis	Ulcers
Cancer/Chemotherapy	Headaches	Prosthetic Heart Valve	**None of the Above**

9. Do you have any disease, condition or problem not listed above? YES NO Explain:_____

I certify that the information given is complete and correct. Any necessary treatment is hereby authorized.

Patient or Legal Guardian Signature _____ **Date** _____

WELL CHILD DENTAL CARE QUESTIONNAIRE: 1-5 YEARS

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your child and support for you. Your answers will be kept private.

Child's Name: _____ DOB: _____ Your name: _____

I am this child's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other:_____

Please check the box for any <u>topics you would like to discuss</u> today:

❑ Your child's behavior	❑ Brushing your child's teeth	❑ Keeping your teeth healthy
❑ What your child eats	❑ Community resources available	❑ Other

Have there been any major changes in your family lately? ❑ Move ❑ Job change ❑ Separation ❑ Divorce ❑ Death in family ❑ Family member went to jail ❑ Any other changes or experiences that impacted your family?

_____

Have any of your child's relatives developed new medical problems since your last visit? ❑ No ❑ Yes (If yes, describe)_____

Please answer a few questions about how you and your child are doing by circling "Yes" or "No"

Do you always feel that you and your child are safe in your home?	Yes	No
Do you give your child supplements, herbs, or vitamins? If yes, please list:	No	Yes
Does your child still use a bottle?	No	Yes
Does your child use a pacifier?	No	Yes
Does your child drink more than 20 ounces of milk per day? If yes, what type:	No	Yes
Does your child drink fruit juice, soda, sports drinks, sweet teas, or other sweet drink daily? If yes, about how many drinks per day:	No	Yes
Does your child eat candy, chocolate, sweet treats, or dessert most days?	No	Yes
Is it difficult to brush your child's teeth?	No	Yes
Does your child spend more than one hour per day in front of a screen?	Yes	No
Is your child up-to-date on his/her vaccinations?	Yes	No
Have you seen your dentist for a check up and cleaning in the past 12 months?	Yes	No

Do you have specific concerns or questions you would like to discuss today? ❑ No ❑ Yes (Please describe)

_____

_____

TURN PAGE OVER ⟶

Please share your contact information with us to make sure that it's up-to-date:

Address: _____

Phone number: _____ ❑ Home ❑ Cell

Whose # is this: _____ ❑ OK for NHC to leave a detailed message

Please complete the following forms today:
❑ Insignia Health Parent Measure

Name	
Parent of	
ID	
Date	

Below are statements people sometimes make about caring for the health of a child. Please indicate how much you agree or disagree with each statement as it applies to you personally as a parent.

Circle the answer that is most true for you today. If the statement does not apply, select N/A.

1.	When all is said and done, I am the person who is responsible for taking care of my child's health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2.	Taking an active role in my child's health care is the most important thing that affects her/his health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3.	I know what each of my child's prescribed medications do.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4.	I am confident that I can tell whether I need to go the doctor or whether I can take care of my child's health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5.	I am confident I can tell a doctor the concerns that I have about my child's health even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6.	I am confident that I can follow through on medical treatments I need to do for my child at home.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7.	I have been able to help my child maintain (keep up with) lifestyle changes, like eating right or exercising.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8.	I know how to prevent problems with my child's health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9.	I am confident I can figure out solutions when new problems arise with my child's health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10.	I am confident that I can help my child maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A