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

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Household Monthly Income According to Documentation $ _____

Documentation Type: _____

Reviewed By: _____

Date _____

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

AUTHORIZATION FOR NHC TO RECEIVE PROTECTED HEALTH INFORMATION

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

I request & authorize the Individual / Clinic / Provider listed below to release a copy of my medical record to NHC:

Name of Individual / Clinic / Provider: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ **Fax:** _____

This authorization gives permission to release the following records:

- Problem list
- Medication list
- Last three progress notes
- Specialty provider consult notes
- All labs, EKG's, and diagnostic studies from previous year
- All pap smear results
- All colonoscopy results
- Immunization record
- Other: _____

I understand that certain information cannot be released without specific permission as required by State / Federal law. By initialing, I authorize the release of the following protected or sensitive information.

(please initial)		(please initial)	
_____	Drug / Alcohol Diagnosis, Treatment, and/or Referral Information	_____	STD / AIDS / HIV Testing
_____	Mental Health Diagnosis and/or Treatment	_____	Genetic Testing

_____

Patient / Guardian Signature ***Relationship to Patient*** ***Date***

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon this authorization. A revocation will not affect inspection of records necessary to validate expenditures by or on behalf of government entities. To revoke this authorization, please send a written statement to Neighborhood Health Center and state that you are revoking this authorization. Unless revoked earlier, this consent will expire upon the event or date indicated: _____ or after one year from the date signed if left blank.

TO THE RECIPIENTS OF PROTECTED HEALTH INFORMATION: The information disclosed to you by this authorization is protected by state law (ORS 179.505, 192.516) and Federal regulations (42 CFR Part 2, 45 CFR Parts 160-164). You are instructed that you may not further disclose this information without the express written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol and drug treatment records. Federal rules restrict the use of alcohol and drug treatment records to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS FOR COMPLETING THIS FORM

Section 1: Complete each box as indicated with the following information:

- Patients Name (Print Clearly)
- Other names patient has used. If none, leave blank
- Date of Birth

Section 2: Write the name or company that is to receive/release the information. Include as much as information as you can:

- Name or Company
- Address (including city, state and zip code)
- Phone number
- Fax number

Section 3: Initial for any sensitive information protected by law you want to be released.

Please sign your name, authorizing the information on the release is correct and approved by you. If you are not the patient, describe your relationship and legal authority to sign. You will be required to provide the legal paperwork. Date the authorization.

PEDIATRIC CONFIDENTIAL HEALTH & SOCIAL HISTORY (0-2 YRS)

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 baby and support for you.

Baby's Name: _____ DOB: _____

Name of person filling out form: _____
I am this baby's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: _____

Is your baby taking any medication regularly? ❑ No ❑ Yes If yes, what: _____
Has your baby been vaccinated? ❑ No ❑ Yes Are your baby's vaccinations up-to-date? ❑ No ❑ Yes ❑ Not sure

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BABY'S HEALTH PROBLEMS (Check box if your baby has had any of these)

❑ Anemia
❑ Asthma / Breathing Problem
❑ Bone / Joint / Muscle Problem
❑ Chicken pox
❑ Diabetes
❑ Ear / Hearing Problem
❑ Eye / Vision Problem
❑ Headaches
❑ Heart Disease / Murmur
❑ Hepatitis
❑ Kidney / Bladder Problem
❑ Other: _____
❑ Mononucleosis
❑ Pneumonia
❑ Rheumatic Fever
❑ Seizures / Epilepsy
❑ Sickle Cell
❑ Stomachaches
❑ Toothache / Decay
❑ Tuberculosis
❑ Usual Bruising / Bleeding Disorder
❑ Whooping Cough

Has your baby been hospitalized or had surgery? ❑ No ❑ Yes When / why: _____
Does your baby have any allergies (medicine, foods, or seasonal)? ❑ No ❑ Yes If yes, what: _____

Has your baby ever been beaten, shaken, or otherwise physically hurt by someone? ❑ No ❑ Yes
Has anybody touched your baby on their private areas without your or your baby's permission? ❑ No ❑ Yes

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MOTHER'S PREGNANCY & BABY'S BIRTH HISTORY (If you filled out this form at NHC in the past, you may skip this section)

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____ Number of living children: _____

Did mother receive prenatal care? ❑ No ❑ Yes How many months pregnant when prenatal care began? _____

Did mother have any problems during pregnancy / labor / delivery? ❑ No ❑ Yes If yes, explain: _____
_____

Did mother use any drugs or medicines during pregnancy? ❑ No ❑ Yes

❑ Alcohol ❑ Street drugs _____ ❑ Over the counter medications_____
❑ Tobacco ❑ Needles to shoot up drugs_____ ❑ Other medicines prescribed by doctor_____

Has mother had treatment for drug/alcohol use? ❑ No ❑ Yes If yes, is mother currently using drugs/alcohol ❑ No ❑ Yes

Birth weight: _____pounds_____ ounces Birth length: _____inches

Born at: ❑ Hospital-Name of hospital: _____ ❑ Home Delivery: ❑ Vaginal ❑ Cesarean

Place of Birth: City _____ State_____ Country _____

Was baby born prematurely? ❑ No ❑ Yes # of weeks pregnant at delivery? _____

BABY'S DEVELOPMENT

Do you believe, or has anyone told you, that your baby is developmentally delayed? ❑ No ❑ Yes

BABY'S DENTAL HISTORY

Has your baby ever been to the dentist? ❑ No ❑ Yes
Do you brush your baby's teeth and mouth daily? ❑ No ❑ Yes
Does your baby use a toothpaste with fluoride in it? ❑ No ❑ Yes
Does your baby take a fluoride supplement? ❑ No ❑ Yes
Do you have any concerns about your baby's teeth? _____

FAMILY MEDICAL HISTORY (Check if a family member had any of these. Family = Your baby's brother, sister, mother, father, grandmother, grandfather)

❑ Alcohol / Drug Problem
❑ Birth Defects
❑ Cancer
❑ Diabetes
❑ Epilepsy / Seizures
❑ Hearing Loss
❑ Heart Attack before age 50
❑ Hepatitis
❑ High Cholesterol
❑ High Blood Pressure
❑ Kidney Disease
❑ Mental Illness
❑ Mental Retardation
❑ Sickle Cell Anemia
❑ SIDS (Sudden Infant Death)
❑ Smoking
❑ Stroke before age 50
❑ Tuberculosis

FAMILY HEALTH HABITS & ACTIVITIES

Baby's parents are: ❑ Married, living together ❑ Married, living apart ❑ Not married, living together
❑ Not married, living apart ❑ Divorced ❑ Separated ❑ Other: _____

Baby lives: ❑ In a house or apartment ❑ In a car or van ❑ In a shelter ❑ Other: _____

Does your baby have any special problems, concerns, or other information you feel your provider should know?

_____

_____

Signature: _____ Date: _____

PEDIATRIC CONFIDENTIAL HEALTH & SOCIAL HISTORY (3-10 YRS)

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.

Child's Name: _____ DOB: _____

Name of person filling out form: _____
I am this child's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: _____

Is your child taking any medication regularly? ❑ No ❑ Yes If yes, what: _____
Has your child been vaccinated? ❑ No ❑ Yes Are your child's vaccinations up-to-date? ❑ No ❑ Yes ❑ Not sure

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CHILD'S HEALTH PROBLEMS (Check box if your child has had any of these)

❑ Anemia	❑ Eye / Vision Problem	❑ Mononucleosis	❑ Stomachaches
❑ Asthma / Breathing Problem	❑ Headaches	❑ Pneumonia	❑ Toothache / Decay
❑ Bone / Joint / Muscle Problem	❑ Heart Disease / Murmur	❑ Rheumatic Fever	❑ Tuberculosis
❑ Chicken pox	❑ Hepatitis	❑ Seizures / Epilepsy	❑ Usual Bruising / Bleeding Disorder
❑ Diabetes	❑ Kidney / Bladder Problem	❑ Sickle Cell	❑ Whooping Cough
❑ Ear / Hearing Problem	❑Other: _____		

Has your child been hospitalized or had surgery? ❑ No ❑ Yes When / why: _____
Does your child have any allergies (medicine, foods, or seasonal)? ❑ No ❑ Yes If yes, what: _____

Has your child ever been beaten, shaken, or otherwise physically hurt by someone? ❑ No ❑ Yes
Has anybody touched your child on their private areas without your or your child's permission? ❑ No ❑ Yes

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CHILD'S DEVELOPMENT
Do you believe, or has anyone told you, that your child is developmentally delayed? ❑ No ❑ Yes

CHILD'S DENTAL HISTORY

Has your child ever been to the dentist?	❑ No	❑ Yes
Has your child ever had a problem at a dentist appointment?	❑ No	❑ Yes
Does your child brush his/her teeth and mouth daily?	❑ No	❑ Yes
Does your child floss daily?	❑ No	❑ Yes
Does your child use a toothpaste with fluoride in it?	❑ No	❑ Yes
Does your child take a fluoride supplement?	❑ No	❑ Yes

Do you have any concerns about your child's teeth? _____

FAMILY MEDICAL HISTORY (Check if a family member had any of these. Family = Your child's brother, sister, mother, father, grandmother, grandfather)

❑ Alcohol / Drug Problem	❑ Heart Attack before age 50	❑ Mental Retardation
❑ Birth Defects	❑ Hepatitis	❑Sickle Cell Anemia
❑ Cancer	❑ High Cholesterol	❑ SIDS (Sudden Infant Death)
❑ Diabetes	❑ High Blood Pressure	❑ Smoking
❑ Epilepsy / Seizures	❑ Kidney Disease	❑ Stroke before age 50
❑ Hearing Loss	❑ Mental Illness	❑ Tuberculosis

Did mother use any drugs or medicines during pregnancy? ❑ No ❑ Yes

❑ Alcohol ❑ Street drugs _____ ❑ Over the counter medications_____
❑ Tobacco ❑ Needles to shoot up drugs_____ ❑ Other medicines prescribed by doctor_____

Has mother had treatment for drug/alcohol use? ❑ No ❑ Yes If yes, is mother currently using drugs/alcohol ❑ No ❑ Yes

FAMILY HEALTH HABITS & ACTIVITIES

Child's parents are: ❑ Married, living together ❑ Married, living apart ❑ Not married, living together
❑Not married, living apart ❑ Divorced ❑ Separated ❑ Other: _____

Child lives: ❑ In a house or apartment ❑ In a car or van ❑ In a shelter ❑ Other: _____

Does your child have any special problems, concerns, or other information you feel your provider should know?

_____
_____

Signature: _____ Date: _____