



# REGISTRATION FORM

<b>Today's Date:</b>		<b>PCP:</b>			
<b>PATIENT INFORMATION</b>					
<b>Patient's Legal Last Name:</b>		<b>First:</b>		<b>Middle:</b>	
<b>Previous Names Used/Alias:</b>	<b>Birth Date:</b> / /	<b>Age:</b>	<b>Social Security #:</b>	<b>Sex at Birth:</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	
<b>Home Phone:</b>	<b>Cell Phone:</b>		<b>Work Phone:</b>		
<b>Mailing Address:</b>		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>E-Mail Address:</b>					
<b>Race:</b> <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> White				<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown	
<b>Sexual Orientation:</b> <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Choose not to disclose		<b>Gender Identity:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female / Male-to-Female <input type="checkbox"/> Transgender Male / Female-to-Male <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to disclose		<b>Preferred Pronoun:</b> <input type="checkbox"/> she/her/hers <input type="checkbox"/> he/him/his <input type="checkbox"/> they/them/theirs <input type="checkbox"/> patient's name <input type="checkbox"/> decline to answer <input type="checkbox"/> unknown	
<b>EMPLOYMENT STATUS</b>					
<b>Employment Status:</b> <input type="checkbox"/> Child <input type="checkbox"/> On Active Military Duty <input type="checkbox"/> Self-Employed <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Not employed				<b>Are you a Veteran?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Number of Family Members:</b>			<b>Monthly Income (before taxes) \$</b>		
<b>LANGUAGE</b>					
<b>What language do you speak at your home:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			<b>Interpreter Needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Preferred:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No Preference		
<b>RESPONSIBLE PARTY</b>					
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					
<b>Parent/Legal Guardian Responsible for Bill:</b>		<b>Birth Date:</b> / /	<b>Social Security # of Parent/Legal Guardian:</b>		
<b>Mailing Address:</b> <input type="checkbox"/> Same as above		<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
<b>Phone Number:</b>		<input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work			

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





## COMBINED CONSENT FORM

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***Patient Name***

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***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.

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***Patient Signature***

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***Date***

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

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***Date***

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***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.*

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
<b>IT IS OK FOR NEIGHBORHOOD HEALTH CENTER TO CONTACT YOU?</b> <i>(please check all that apply):</i>	
1. Can we send bills to your address? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Can we send automated appointment reminders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which type? <input type="checkbox"/> Phone call <input type="checkbox"/> 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.) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Care <input type="checkbox"/> Yes <input type="checkbox"/> No Behavioral Health (follow up on concerns, referrals, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No Reproductive Health (sexual health, STI treatment, test results) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Preferred Communication:</b> <input type="checkbox"/> Do not contact <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> email via MyChart <input type="checkbox"/> No preference	
<b>If the answer to any of the above is No, how may we reach you regarding your critical healthcare?</b>	
<b>Name of contact:</b> _____	
<b>Phone number:</b> _____	
<i>**If you sign up for MyChart, all your information is available online. Ask the receptionist to help you sign up for MyChart**</i>	
<b>WHO MAY WE SPEAK TO REGARDING YOUR HEALTHCARE? &amp; EMERGENCY CONTACTS</b> <i>(NOTE: this is not an authorization to release records):</i>	
I authorize Neighborhood Health Center to speak to the following people, in person or by telephone: <input type="checkbox"/> Not Applicable	
<b>Name:</b> _____	
<b>Relationship:</b> _____	<b>Phone:</b> _____
<input type="checkbox"/> Use this person as an emergency contact <input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence	
Regarding <i>(please check all that apply)</i> :	
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Schedule / cancel appointment <input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> All information	<input type="checkbox"/> Lab results <input type="checkbox"/> Imaging results
<input type="checkbox"/> Other: _____	
<b>Name:</b> _____	
<b>Relationship:</b> _____	<b>Phone:</b> _____
<input type="checkbox"/> Use this person as an emergency contact <input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence	
Regarding <i>(please check all that apply)</i> :	
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Schedule / cancel appointment <input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> All information	<input type="checkbox"/> Lab results <input type="checkbox"/> Imaging results
<input type="checkbox"/> Other: _____	
<b>Name:</b> _____	
<b>Relationship:</b> _____	<b>Phone:</b> _____
<input type="checkbox"/> Use this person as an emergency contact <input type="checkbox"/> Authorized to sign on behalf of guardian in guardian's absence	
Regarding <i>(please check all that apply)</i> :	
<input type="checkbox"/> Prescription drug information	<input type="checkbox"/> Schedule / cancel appointment <input type="checkbox"/> Medical instruction / advice
<input type="checkbox"/> All information	<input type="checkbox"/> Lab results <input type="checkbox"/> Imaging results
<input type="checkbox"/> 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		OFFICE USE ONLY	
<b>Family Size</b>	<b>Monthly Income 200% or Less</b>	Household Monthly Income According to Documentation	\$ _____
1	\$2,023.00	Documentation Type:	_____
2	\$2,743.00		
3	\$3,463.00		
4	\$4,183.00	Reviewed By:	_____
5	\$4,903.00		
6	\$5,623.00		
7	\$6,343.00	Date	_____
8	\$7,063.00		

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	<b>None of the Above</b>

- 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** \_\_\_\_\_