ACCESS FAMILY CARE

PATIENT REGISTRATION

Please complete the front and back of this form. Please PRINT. Please return completed form(s) to the Front Desk. Thank you.

PATIENT INFORMATION

Date: ____/____/____ **Name:** _____ **Sex:** □ Male □ Female
FIRST MI LAST

Primary Language: □ English □ Spanish □ Other _____ □ I require an interpreter

Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Multi-racial □ Other _____ □ White □ Decline to answer

Ethnicity: Are you of Hispanic or Latino (Persons of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture) origin? □ YES □ NO □ Decline to answer **Are you a Veteran?** □ YES □ NO

Date of birth: ____/____/____ **SSN:** _____ **Status:** □ Single □ Married □ Widowed □ Divorced □ Separated □ Child □ Other

Home phone: (____)_____ **Cell phone:** (____)_____

Street Address: _____ **P O Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Email address: _____

Patient Employer: _____ **Phone:** (____)_____

Does the patient reside in a nursing home or residential care facility? □ YES □ NO If **YES**, what is the name of the facility where the patient resides? _____ Phone number: (____)_____

SPOUSE INFORMATION (if applicable)

Name: _____ **Date of birth:** ____/____/____ **SSN:** _____
FIRST MI LAST

Employer: _____ **Phone:** (____)_____

EMERGENCY CONTACT INFORMATION

Name and telephone number of someone who does not live in your household

Name: _____ **Relationship to Patient:** _____
FIRST LAST

Phone: (____)_____

Form #622

RESPONSIBLE PARTY INFORMATION

Complete this section if the Responsible Party is NOT the Patient

Relationship of Responsible Party to the Patient: □ Self □ Spouse □ Parent □ Legal Guardian □ Other _____

NAME: _____ **Sex:** □ Male □ Female
FIRST MI LAST

Date of birth: ____/____/____ **SSN:** _____

IF ADDRESS IS NOT THE SAME AS THE PATIENT: Street: _____ **P O BOX** _____

City: _____ **State:** _____ **Zip Code:** _____ **Home phone(**____**)**_____

Employer: _____ **Phone:** (____)_____

INSURANCE INFORMATION

Please present your insurance card to the Front Desk each time you check-in

Do you have insurance? □ MEDICAL □ DENTAL

If YES to Medical Insurance, type of coverage: □ Medicare □ Medicaid □ Commercial □ Individual policy □ Other _____

Please present ALL insurance cards to Front Desk.

****

Number of Persons in Household: Adults _____ Children (<18 years old) _____

Estimated Annual Household Income: □ $10,000 or below □ $10,001 - $20,000 □ $20,001 - $30,000 □ $30,001 - $40,000 □ $40,001 - $50,000 □ $50,001 and over

****

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

- I give my consent as the patient or primary legal custodian or joint legal custodian of the patient for any treatment or procedure deemed necessary by the professional staff of ACCESS Family Care.
- I understand this treatment may include x-rays and/or lab work. I understand that an emergency dental visit may consist of a diagnosis of the condition and treatment necessary to relieve discomfort. However final treatment may require additional visits.
- I give permission for ACCESS Family Care to furnish any information needed for my or the patient's billing and treatment.
- I agree to be financially responsible for all charges and understand payment in full is expected at the time of service.
- I request that payment of Medicare, Medicaid or other insurance company benefits made on my behalf or that of the patient's to be assigned to ACCESS Family Care.

_____ I have received a copy of the ACCESS Family Care Notice of Privacy Practices. I understand that it is my responsibility to read
INITIALS this notice and ask any questions I might have.

_____ I have received a copy of the ACCESS Family Care Patient Rights. I understand it is my responsibility to read and follow the
INITIALS information contained in this notice.

_____ I have received a copy of the ACCESS Clinic Appointment Policy. I understand that attendance issues may cause me to be
INITIALS dismissed as a patient with ACCESS Family Care and I agree it is my responsibility to follow this policy.

- I agree that my consent is valid as long as I am a patient at ACCESS Family Care.

_____ _____
Signature of Patient/Responsible Party **Date**

_____ □Joplin-Medical □ Cassville-Medical □ Anderson-Medical
Signature of ACCESS Family Care Staff Member □Joplin-Dental □Anderson-Dental

4301 Doniphan Drive, Neosho, MO
417-451-9450

ACCESS FAMILY CARE

Name: _____ **Date:** _____

Allergies: _____ **Reaction (hives, rash, etc)** _____

PERSONAL MEDICAL HISTORY: Check any conditions you have or have had in the past:

☐Aids/HIV	☐Diabetes	☐High Blood Pressure
☐Alcoholism	☐Emphysema	☐Kidney Disease
☐Anemia	☐Glaucoma	☐Liver Disease
☐Arthritis	☐Goiter	☐Migraines
☐Asthma	☐Gout	☐Prostate Problems
☐Bleeding Disorders	☐Heart Disease	☐Stroke
☐Back Pain	☐Hepatitis	☐Thyroid Problems
☐Cancer	☐High Cholesterol	☐Tuberculosis

SURGICAL HISTORY: Check all that apply

☐Appendectomy	☐Hernia	☐Coronary Bypass	☐Cataracts
☐Tonsillectomy	☐Hysterectomy	☐Vasectomy	☐Mastectomy
☐Gall Bladder	☐Ovaries Removed	☐Tubal Ligation	☐Carpal Tunnel

☐Other_____

FAMILY HISTORY: Please indicate the history of your **immediate** family members: Please indicate which family member (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

☐Alcoholism_____	☐High Blood Pressure_____
☐Cholesterol_____	☐Stroke_____
☐Cancer, specify type_____	☐Bleeding/Clotting_____
☐Heart Disease_____	☐Diabetes_____
☐Depression/Suicide_____	☐Asthma/COPD_____
☐Other: _____	

SOCIAL HISTORY

TOBACCO USE

Cigarettes: ☐Never ☐Quit Date_____ ☐Current: Packs/day_____# of yrs_____ **Other Tobacco:** ☐Pipe ☐Cigar ☐Snuff ☐Chew

ALCOHOL USE

Do you drink alcohol? ☐Yes ☐No # drinks/week_____

DRUG USE

Do you use any recreational (street) drugs? ☐Yes ☐No

OTHER CONCERNS

Caffeine Intake: ☐None Coffee/tea/soda_____cups/day

EXERCISE: **Do you exercise regularly?** ☐Yes ☐No

What kind of exercise? _____ **How many times a week?** _____

SAFETY: **Do you use seatbelts consistently?** ☐Yes ☐No

SOCIOECONOMICS: **Occupation:** _____ **Place of employment**_____

Marital Status: ☐Single ☐Partner/Married ☐Divorced ☐Widowed ☐Other

Are you a veteran? ☐Yes ☐No

WOMEN'S HEALTH HISTORY

 # Of: Pregnancies_____ **Live Deliveries**_____ **Abortions**_____ **Miscarriages**_____ **Living Children**_____

Date of last menstrual period_____

Are you menopausal? ☐Yes ☐No **If yes, age of onset**_____

Date of last pap smear_____ **Result:** ☐Normal ☐Abnormal

(Continued on back)

Current Medication List **Name** _____ **Date** _____

Name of Medication	Strength	How Often

What is your current health problem? _____

_____

_____

Tell us about that problem:

_____

_____

_____

_____

_____

_____

_____

Revised: 2/14/11

ACCESS FAMILY CARE

4301 Doniphan Drive
Neosho, MO
417-451-9450

Medical Appointment Agreement

Arriving Late
If you arrive more than ten (10) minutes late for your appointment, you will need to reschedule your appointment.

Cancellations
If you cannot come to your appointment, please call at least twenty-four (24) hours before your scheduled appointment. This will enable us to schedule another patient at this time.

Failed Appointments
If you do not come to your scheduled appointment, you will need to call and reschedule your appointment (see cancellations).

If you fail to come to your appointment or cancel your appointment three (3) times, you will be seen as a walk-in only.

After you are seen as a walk-in only, you must wait a period of three (3) months before you will be eligible to receive scheduled appointments.

I understand and agree to follow the Medical Appointment policy.

_____ _____

Signature of patient or guardian Date

Form 661 Rev. 11/10/08/name

4301 Doniphan Drive
Neosho, MO 64850
417=451-9450

ACCESS FAMILY CARE

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information
- How we may use and disclose the health information that we keep about you.
- You rights relating to your personal health information.
- Our right 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.

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient acknowledgment of receipt

I, _____hereby acknowledge that I have received a copy of the Notice of Privacy Practice.

_____

Patient's Signature Date

_____

Signature of Parent or Patients Representative (if applicable) Date

_____

Description of Legal Authority to Act on Behalf of Patient Date

ACCESS Family Care
□ 530 Maiden Lane, Joplin, MO 64801
□ 927 N. Hwy 71 Bus., Anderson, MO 64831
□ 4016 N. Main Street, Cassville, MO 65625
□ 412 E. McKinney, Neosho, MO 64850

Rev. 4-19-12/addresses

ACCESS Family Care

Consultation/Exam Waiver of Rights of Confidential Health Information

I waive my confidentiality rights by requesting to have other people present as designated below, during examinations and/or consultation that may disclose my private health information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Request for additional release of information (by phone, mail, in person)

I give my permission to discuss with the individual(s) I have listed:
Please mark the appropriate box (s):

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I understand that I am responsible for notifying this office in writing of any changes to this authorization to disclose my personal health information.

Patient Name: _____ DOB: _____ Age: _____ Chart # _____

Providers Signature: _____ Date: _____

Form 640