Scenic Bluffs COMMUNITY HEALTH CENTERS

PATIENT REGISTRATION FORM – PLEASE PRINT

First Name: ___________________________________ **MI**: _____**Last Name**: ____

Has patient ever used a different last name? ❑ Yes ❑ No ***If yes, what name?** ____________________________________

Street Address____

City: _______________________________**State**:________ **Zip Code**: ________________ **County:** _______________________

Primary Phone: ❑ Home ❑ Work ❑ Cell # ____

Secondary Phone: ❑ Home ❑ Work ❑ Cell #____

Who is your Primary Medical Care Provider?

❑ Scenic Bluffs Provider____

❑ Other ____

Name of Medical Clinic ____

Who is your Primary Dental Care Provider?

❑ Scenic Bluffs Provider____

❑ Other ____

Name of Dental Clinic ____

Date of Birth: ________/_________/__________

Gender Identity: ❑ Male ❑ Female ❑ Transgender Male ❑ Transgender Female ❑ Other ❑ Choose not to disclose

Patient is: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Social Security#:_________-_________-_________ ❑ none

Is patient employed? ❑ Yes ❑ No

Employer's Business Name: ____

Employer's Address, City, State, Zip____

Phone#:____

Is patient a student? ❑ YES ❑ NO

If yes: ❑ Full-time ❑ Part-time

BILLING INFORMATION- **Who is financially responsible for paying patient's bill?** ❑ Patient ❑ Other

If person responsible for bill(s) is different than patient: → *fill in below* ↓

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Step Mother ❑ Step Father ❑ Guardian ❑ Foster Parent ❑ POA

First: ______________________________ MI: __________ Last: ____

Street Address: ____

City: ______________________________________ State: _______ Zip: ________________ Telephone #:_______________________

CONTINUED ON REVERSE SIDE →

Social Security #: ____________-___________-_____________ Date of Birth: __________/__________/____________

Employer's Business Name: ____ Telephone #: ____________________

Employer's Address, City, State, Zip: ____

Is the patient covered by insurance? ❑ Yes ❑ No **Please present insurance cards to front desk staff.**
*Without accurate insurance information, Scenic Bluffs is unable to accurately submit claims on your behalf and you, or person financially responsible for **paying the patient's bill, will be issued a statement for the costs for all services provided at patient's visit. If you do not have health insura**nce, we offer a sliding fee scale called the Health Neighbor Plan.*

We offer a Sliding Fee Program- the Healthy Neighbor Plan- to those who qualify. Fill out the application provided to enroll. ❑ Already Enrolled

Email address: ____

Race: ❑ White ❑ Asian ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Other__________________________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

What language is patient best served in? ❑ English ❑ Spanish ❑ Other____

Which Pharmacy do you use?
- ❑ Scenic Bluffs Pharmacy
- ❑ Other- List Name/Location of Pharmacy____

Do you understand English? ❑ YES ❑ NO
If no: Do you require a translator? ❑ YES ❑ NO
If no: What language other than English do you understand? ____

Is patient a Veteran? ❑ YES ❑ NO

Is patient Amish? ❑ YES ❑ NO

Is patient Homeless? ❑ YES ❑ NO

Public Housing? ❑ YES ❑ NO

Special Needs: ❑ YES ❑ NO
If yes, please select: ❑ Vision Impairment ❑ Hearing Impairment ❑ Cognitive Issues ❑ Other

Sexual Identity: ❑ Straight ❑ Lesbian or gay ❑ Bisexual ❑ Something else ❑ Don't know ❑ Choose not to disclose

Is someone other than patient responsible for healthcare decisions? ❑ YES → *if yes fill in below* ↓

Are you related to the patient? ❑ YES ❑ NO Relationship? ____

Are you a Foster Parent/Legal Guardian? ❑ YES ❑ NO If guardian, please provide documentation.

Parent/Guardian Full Name: ____ Date of Birth: __________/________/____________

Street Address: ____

City: __________________________________State:__________ Zip: _______________ Telephone #:_______________________

Any other parent/legal guardian? ❑ YES ❑ NO **Relationship?** ____

Parent/Guardian Full Name: ____ Date of Birth: ________/_______/____________

Street Address (if different than above): ____

City: ____________________________ State: ____________ Zip: ___________________ Telephone #:__________________________

Substituted Consent for Treatment

To comply with Wisconsin law, Scenic Bluffs Community Health Center requires that a legal guardian (guardian appointed by a court) consent to care when they are unable to attend appointments. In the event that a legal guardian is unable to consent to care, the legal guardian may delegate the right to consent to another adult. In the event that a patient presents for a non-urgent appointment without a legal guardian or a signed consent, treatment may be denied.

Release of Information: To ensure that the Parent Substitute(s) has access to Patient Health Information needed to make informed consent decisions, I/We authorize Scenic Bluffs Community Health Center to provide the Parent Substitute(s) with Patient Health Information relating to the Minor Patient. "Patient Health Information" means all medical records and treatment records relating to the Minor Patient which are protected and confidential under 42 C.F.R. Part 2, Wis. Stat. §§51.30 and 146.82, the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), and the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Regulations"), 45 C.F.R. Part 160 and Part 164, subparts A and E.

It is only necessary to complete section 1 and 3 if granting permission for patient to be seen without a parent/guardian.

Section 1:

Patient's name: ______________________________ **Patient's Date of Birth:** ______________

During the period: ______________ to ______________ ☐ **or until patient is 18 years of age**
(Start Date) (Ending Date)

In the event Scenic Bluffs Providers need to contact you before providing care please provide the following information:

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Other: ______________________

Would you like the patient to be seen without a parent/guardian present? ____Yes ____No
(Parent/Guardian may be required to attend for certain procedures)

Section 2:
I delegate the right to consent to the following adult(s)

Adult Appointee's Name: ______________________________

Relationship (to patient): ______________________________

Appointee's Address: ______________________________

Appointee's Phone Number: ______________________________

Section 3:
I agree to reimburse Scenic Bluffs Community Health Center for the cost of rendering these services to the extent that my insurance does not pay for these services.

______________________________ ______________________
Parent/Legal Guardian Signature **Relationship**

______________________________ ______________________
Parent/Legal Guardian Printed Name **Date**

AUTHORIZATION FOR TREATMENT/PAYMENT AND RELEASE OF INFORMATION
&
ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES
&
ACKNOWLEDGMENT OF PHARMACY RELEASE

Patient Name: ____ **Date of Birth:** ____________________

-I hereby authorize Scenic Bluffs Community Health Centers to provide services as considered necessary and/or appropriate.

-I hereby authorize Scenic Bluffs Community Health Centers to disclose any medical or other health information to my insurance carrier or its agent **should it be needed for payment of claims**.

-I UNDERSTAND THAT IF I RECEIVE TREATMENT FOR **MENTAL ILLNESS, HIV, DEVELOPMENTAL DISABILITIES, DRUG AND ALCOHOL ABUSE, THESE RECORDS ARE INCLUDED**.

-I assign payment directly to Scenic Bluffs Community Health Centers for benefits otherwise payable to the insured.

-I understand that I am financially responsible for the services rendered, or materials and equipment used to the extent that insurance benefits do not pay my bill. This is a family purpose obligation and our marital assets as well as my individual assets shall be available to satisfy this obligation.

-A photocopy/facsimile of this authorization shall be as valid as the original and may be cancelled at any time.

-I acknowledge that I have received a copy of Scenic Bluffs Community Health Centers' Notice of Privacy Practices.

-I authorize Scenic Bluffs Health Center and it's providers to view my external prescription history via Surescripts and/or AllScripts prescription service. I understand that prescription history from multiple other unaffiliated providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understand the scope of my consent and that I authorize access.

____ ______________________

Signature **Date**

____

Printed Name of Person Signing (If Not Patient) **Relationship (check one):** ☐ Parent ☐ Legal Guardian

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AUTHORIZATION FOR COMMUNICATION OF HEALTH INFORMATION

PATIENT NAME: ____ **DATE OF BIRTH:** ____________________

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), Scenic Bluffs Community Health Center must have your specific authorization to share any of your Protected Health Information (PHI) with a spouse or family member, or to leave a message regarding your health care on your telephone answering machine.

This is especially helpful if you

- are on medications that require frequent testing and adjustment,
- in case there is an urgent need to contact you,
- if we need to reschedule an appointment, test or procedure and you are not available when we call
- if there is someone who assists with your finances,
- if you use a driving service or personal driver who you would like to call to confirm your appointments.

The type of information disclosed could be

- Account/billing information
- Appointment information (dates and times)
- Medical history of diagnostic and therapeutic information, this may include information regarding mental health, developmental disability, HIV, alcohol and drug abuse, unless otherwise specified below.

This form **DOES NOT** authorize the disclosure of any of your written health information. You can choose to limit the health information that is shared with any person or agency that you list.

Verbal Communication regarding my treatment can be shared with (please print):

Name / Relationship	Phone Number	Type of Information
____________________/______________	__________________	❑ All ❑ Limited to: ____________________
____________________/______________	__________________	❑ All ❑ Limited to: ____________________
____________________/______________	__________________	❑ All ❑ Limited to: ____________________

If under 18 years of age, list parent names below:

MOTHER:____

FATHER:____

IN CASE OF EMERGENCY…

Name of local friend or relative: ____

Relationship to patient: ______________________________ Phone Number:______________________________

Please indicate below where we may contact you and leave a message regarding your Medical, Behavioral Health and/or Financial information, if appropriate:

HOME: ___________________________ **CELL:**________________________ **WORK:** ____________________

You may refuse to sign this authorization with the understanding that this may results in a delay of treatment and/or potentially adverse health consequences. By signing this form, you understand that at any time, you may change or revoke this authorization. This authorization will expire in two years from the date signed.

____ _________________________________

Signature of Patient/Parent/Legal Guardian Date

____

(If signed by authorized person, state relationship and authority to do so.)

Scenic Bluffs
COMMUNITY HEALTH CENTERS

Dental Health Review

Name: ________________________________ **Date of Birth:** _________ **Today's Date:**_________

Have you ever been told you have any of the following conditions?

- ☐ Abnormal bleeding (following tooth extraction or surgery)
- ☐ Acid reflux
- ☐ Addison's Disease
- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Anxiety/Behavioral Health Concerns
- ☐ Angina
- ☐ Ankle swelling
- ☐ Arthritis, rheumatism
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chest pain upon exertion
- ☐ Chronic back/neck/joint pain
- ☐ Congenital heart defect
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Diabetes Type_____
- ☐ Extra pillows when you sleep
- ☐ Glaucoma
- ☐ Gum Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Transplant
- ☐ Hepatitis Type____
- ☐ High Blood Pressure
- ☐ HIV infection/AIDS
- ☐ Infective Endocarditis
- ☐ Joint replacement
  If yes, year_________
  Joint replaced_________
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Liver disease, jaundice
- ☐ Malignant hyperthermia
- ☐ Mental condition
  If yes, type____________
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Neurological condition
  If yes, type____________
- ☐ Orthopedic pins/rods/screws
- ☐ Osteoporosis
- ☐ Other cardiovascular conditions
  Describe________________
- ☐ Pacemaker
- ☐ Persistent cough or cough up blood
- ☐ Prosthetic devices/implants
- ☐ Prosthetic Heart Valve
- ☐ Radiation/chemotherapy
- ☐ Rheumatic fever, rheumatic heart disease
- ☐ Seizures
- ☐ Sexually Transmitted disease
- ☐ Shortness of breath after exercise or when lying down
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Vascular disease
- ☐ Other (list below)

OTHER:____

Do you use tobacco products? **Yes** **No**

Are you pregnant? **Yes** **No**
Are you nursing? **Yes** **No**

List past hospitalizations:

Are you ALLERGIC, or have you had any reaction to:

- ☐ No known drug allergies
- ☐ Local anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Aspirin or other pain meds
- ☐ Other__________________

List all medications, herbs and supplements that you take.

Do you have a primary medical care provider? ☐ YES ☐ NO

Are you interested in learning how Scenic Bluffs can become your Medical Home? ☐ YES ☐ NO

To the best of my knowledge, the above information is correct.

Signature____ **Date**________________