Patient Registration Form

Healthy Connections
Community Health Network
Medical • Dental • Behavioral Health • Outreach

Today's Date _____ **SSN** _____ **DOB** _____

First Name _____ **MI**____ **Last Name** _____

Sex at Birth ☐M F ☐ **E-Mail** _____ **DL#**_____

Address _____ **City** _____ **State/Zip** _____

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Other Phone (list whose phone)** _____

Marital Status ☐ M ☐ S ☐ D ☐ W **Student Status** ☐ FT ☐ PT ☐ NO **Veteran Status** ☐Yes ☐ No

Sexual Orientation ☐ Straight (not lesbian/ gay) ☐ Lesbian/ Gay ☐ Bisexual ☐ Choose not to disclose

Gender Identity ☐ Male ☐ Female ☐ Transgender male (female to male) ☐ Transgender female (male to female)
☐ Choose not to disclose

Employment ☐ Full Time ☐ Part Time ☐Unemployed ☐ Retired

Patient employed by _____ **Occupation** _____

Spouse's Name_____ **Spouse's Employer** _____

Number in Household_____

Household Income Level ☐ $ 0- $11,999 ☐$ 12,000- $19,999 ☐ $ 20,000- $27,999 ☐ $ 28,000- $39,999
☐ $40,000- 49,999 ☐ $50,000- $69,999 ☐ $70,000 and up ☐ Choose not to disclose

Language ☐ English ☐ Spanish ☐Other_____

Race ☐ African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ White

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

You may be eligible for a discount on your medical or dental charges. Please ask to speak with the Financial Counselor for assistance.

Guarantor Information (If under the age of 18)

Insurance Policy Holders First Name _____**MI**____ **Last Name**_____

Relationship to Patient _____ **Employer** _____

DOB _____ **SSN** _____

Address _____ **City** _____ **State/Zip** _____

Home Phone _____ **Work Phone** _____

Emergency Contact _____ **Relation**_____

Phone _____ **This is a** ☐ Home ☐ Work ☐ Cell Phone

Does contact reside with patient? ☐ Yes ☐ No

If no, please list address _____

How confident are you filling out medical forms by yourself? _____

1. Extremely **2.** Quite a bit **3.**Somewhat **4.**A little **5.** Not at all

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CONSENT TO TREATMENT

I, _____, voluntarily consent to outpatient care involving routine diagnostic procedures, examination, medical treatment including those procedures deemed medically appropriate by Healthy Connections, Inc. providers.

I authorize the clinic to release information to insurance carriers to process claims and authorize payment of medical benefits to the undersigned physician or supplier for services described below. I further authorize release of medical information to my medical providers or anyone I designate in writing. This Consent to Treatment remains in effect until I revoke in writing.

HIPAA Confirmation: I have had the opportunity to read and understand the Health Insurance Portability and Accountability Act policies in use by Healthy Connections, Inc.

PHOTOGRAPH: I hereby consent Healthy Connections, Inc. to photograph me (or my minor child) and relieve HCI of any responsibility for the use of my photograph for treatment, identification, and education purposes only.

ASSIGNMENT & RELEASE: I agree to assign directly to Healthy Connections, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the attending medical providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that this consent form will valid and remain in effect as long as I (he/she) attend the clinic. This form has been fully explained to me and I understand its contents.

_____ _____
Patient Signature Date

_____ _____
Parent and/or Guardian Signature for Minor Child Date

___ I understand that if my child is receiving treatment, I am signing this form on their behalf. As the responsible party of a minor child, I am consenting for my child to receive treatment at this clinic.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Date:_____

Guarantor's Signature:_____ Date:_____

I appoint the following individual(s) to act as my healthcare representative with whom my health information may be disclosed.

Name: _____ Phone Number: _____
Relationship: _____
Name: _____ Phone Number: _____
Relationship: _____
Name: _____ Phone Number: _____
Relationship: _____

You have the right to make changes in writing to this acknowledgement. You have the right to refuse to sign this acknowledgement. If you refuse to sign this acknowledgement we may be forced to refuse to administer treatment based on our inability to properly file your insurance and/or seek medical/dental/mental healthcare consultation and referral services.

Dental Patient History

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Patient Name: _____ DOB: _____

Are your teeth sensitive to; Son sus dientes sensibles al;		
Heat/ Calor	**Yes**	**No**
Cold/ Frio	**Yes**	**No**
Sweets/ Cosas Dulces	**Yes**	**No**
Do you feel pressure in your jaw or teeth when biting? Siente dolor o presion en su quijada o dientes al morder?	**Yes**	**No**
Do your gums bleed when brushing? Le sangran las encias cuando se cepilla?	**Yes**	**No**
Have you noticed any gum swelling? Ah notado las encias hinchadas?	**Yes**	**No**
Do you have an unpleasant taste or odor in your mouth? Tiene un sabor desagradable u olor en su boca?	**Yes**	**No**
Do you have pain in your jaw, ears, or sides of face? Siente dolor en sus quijadas, oídos, o a los lados de la cara?	**Yes**	**No**
Do you have difficulty opening and closing your mouth? Tiene dificultad al abrir y cerrar su boca?	**Yes**	**No**
Does your jaw pop, click or hurt when opening your mouth or chewing? Al abrir su boca o masticar, le truena la quijada o le duele?	**Yes**	**No**
Do you have headaches? Tiene dolores de cabeza?	**Yes**	**No**
Do you have any other specific problems with your teeth? (Tiene problemas especificos con sus dientes)? **Specify:** _____ Especifique;_____	**Yes**	**No**
Do you use tobacco of any kind? Fuma o masca tabaco?	**Yes**	**No**

To the best of your knowledge, are you or have you been afflicted with; Segun su conocimiento, esta o se ha enfermado de;		
Heart Ailment / Enfermedad del corazon		
A)**Heart Attack**/ Ataque al corazon	**Yes**	**No**
B)**Heart Valve**/ Valvula del corazon	**Yes**	**No**
C)**Heart Stents (or) bypass**/Stents Cardiacos	**Yes**	**No**
Rheumatic Fever / Fiebre Reumatica	**Yes**	**No**
Epilepsy/ Epilepsia	**Yes**	**No**
High Blood Pressure/ Presion Alta	**Yes**	**No**
Respiratory Disease/ Enfermedad Respiratoria		
A) **COPD**/ EPOC	**Yes**	**No**
Hepatitis/ Hepatitis		
1)A	**Yes**	**No**
2)B	**Yes**	**No**
3)C	**Yes**	**No**
Healing Complications/ Complicacion para sanar **Describe**-Describa: _____	**Yes**	**No**
HIV or Aids/ VIH o Sida	**Yes**	**No**
Anemia/ Anemia	**Yes**	**No**
Diabetes/ Diabetes		
1)**Type**/ Tipo I	**Yes**	**No**
2)**Type**/ Tipo II	**Yes**	**No**
Received Dialysis/Ah recivido Dialisis	**Yes**	**No**
Kidney Disease/ Enfermedades del los Riñones	**Yes**	**No**
Liver Disease/ Enfermedades del Higado	**Yes**	**No**
Tuberculosis/ Tuberculosis	**Yes**	**No**
Human Papillona Virus/ Virus del Papiloma Humano		
1)**Herpes**/ Herpes	**Yes**	**No**
2)**Other**/ Otro: _____		
STD's/ Enfermedades de Transmision Sexual	**Yes**	**No**
Joint Replacement/ Remplazamiento de Coyunturas **If yes, which joint**? / _____ Si si,cual coyuntura? ____ **How long ago**?/ Hace cuanto?_____	**Yes**	**No**
Asthma/ Asma	**Yes**	**No**
Do you have Prolonged Bleeding/ Sangrado prolongado?	**Yes**	**No**
1) **Do you take Aspirin?** / Toma Aspirina?	**Yes**	**No**
2) **Do you take Blood Thinners?** / Toma Adelgasadores de la Sangre?	**Yes**	**No**

Answer / Conteste SI (**Yes**) or NO (**No**)

Have you or are you currently receiving Steroid Therapy/ Esta o ah recevido terapia de esteroides? 1)**Medication name**/ Nombre de medicamento_____ 2) **How much do you take? /** Cuanto tomo (a)? _____ 3) **How long ago did you take it? /** Por cuanto tiempo lo tomo?	**Yes**	**No**
Are you allergic to any medications? / Es alergico a algun medicamento? **If yes please specify**/ si respondio si, porfavor especifique; _____	**Yes**	**No**
Have you ever had any teeth removed? / Le an sacado algun diente o muela? **If Yes, how long have these teeth been missing? /** Si su respuesta fue si, hace cuanto que perdio esos dientes? _____	**Yes**	**No**
Do you believe you will eventually wear artificial dentures? Cree que eventualmente tendra que usar dentaduras artificiales?	**Yes**	**No**
Do you presently wear artificial dentures? **If yes when was this denture made? _____** Presentemente usa dentaduras artificiales? Si su respuesta fue si, cuando fue esta dentadura hecha?_____	**Yes**	**No**
Are you pregnant? / Esta embarazada?	**Yes**	**No**
Have you had or do you currently have cancer? / Ah tenido o tiene cancer? **If yes, what type? /** Que tipo? _____ **Did you have chemeotherapy? /**Tuvo quimeoterapia? _____ **Did you have radiation therapy? /** Tuvo terapia de radiacion? _____	**Yes**	**No**
Have you had or do you currently have Osteoporosis? / Tiene o ah tenido Osteoporosis? **If yes, have you had bisphosphonate therapy**? _____ Ah tenido terapia de Bisfosfonato? _____ **Are you currently or did you have to take Fosamax, Boniva, Topamax**?_____ Esta o ah tenido que tomar Fosamax, Boniva, Topamax?_____	**Yes**	**No**
Have you ever had a reaction to dental anesthetic? Alguna vez ah tenido alguna reaccion a la anestecia dental?	**Yes**	**No**
Have you ever been hospitalized or had any surgeries? Alguna vez ah sido hospitalizado o ah tenido alguna cirugia? **If yes, specify:_____** Si su respuesta fue si, especifique:_____	**Yes**	**No**

Please list any current medications you are taking (prescription and/or over the counter)
Porfavor liste los medicamentos que actualmente esta tomando (ya sean medicinas recetadas o sin receta).

1) _____ 6) _____
2) _____ 7) _____
3) _____ 8) _____
4) _____ 9) _____
5) _____ 10) _____

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Prescription Medication Policy and Refill Request

- ***New Prescriptions will not be issued without first seeing your physician/provider***
- ***It is the responsibly of all Healthy Connections, Inc.'s (HCI) Patients to request refills of the HCI prescribed medications from patient's pharmacy.***
- Refills of medications prescribed by HCI providers require **72 hour advance notice to refill**. This give the pharmacy time to document the request and submit it to one of the Healthy Connections facilities.
- Upon receipt of the request from your pharmacy, an HCI ***medical clinician*** will review your medical record and determine if, A) You need to schedule an office visit prior to approving the prescription refill. B) You need additional testing prior to approving the prescription refill. C) The refill is approved without need for an office visit at this time.
- Upon determination by the medical clinician, A) You will be called to schedule an appointment with the medical provider or B) The approved prescription refill request will be sent to your pharmacy.
- REMEMBER, contact your pharmacy to check to see if your prescription is ready and ONLY after 72 hours from the time you first called your pharmacy has passed.
- If you change pharmacies, you MUST re-sign this form.

NO EARLY REFILLS WILL BE APPROVED

- **Schedule II Narcotic prescription (i.e., Morphine, Oxycodone, Fentanyl, etc.) refill requests require 5-7 days** to approve and MUST be picked up at the HCI reception desk. Only an original, hard-copy prescription will be accepted at your pharmacy according to state and federal prescription guidelines, refills will not be granted BEFORE 30 days have lapsed since your last refill date. Patients must have a current Pain Management agreement on file at HCI designating a local pharmacy.
- Our clinic **does not** provide pain management services. In some circumstances, we may prescribe a controlled substance/narcotic to a patient. We require you to provide us with names of any other medical/dental providers that you may have seen in the past year that has prescribed you this type of medication. We also require you to disclose the name of the pharmacy you will use. You, as part of your treatment, will be required to refrain from receiving this type of medication from any other providers during your course of treatment with us. **If we obtain information that you have filled or received a prescription from another provider during your treatment with us, we will contact the prosecuting attorney's office or local law enforcement and provide them with this information.** By initialing beside this policy, you give us the right to report this information. If you break this policy or do not disclose **all** information, we will terminate our physician/patient relationship.

My preferred pharmacy location is: ☐ Healthy Connections Community Pharmacy, Mena ☐ Medi Shop Pharmacy, Mena

☐ Mt. Ida Pharmacy, Mt. Ida ☐ Woodard Family Pharmacy, Glenwood ☐ Oak Park Pharmacy, Hot Springs

☐ Millers Drug Store, Malvern ☐ Other _____

I, _____, understand and will comply with HCI's prescription refill request policy. I understand that my prescription may be ready before 72 hours has passed, however, to ensure the highest level of patient care, it is important that I allow my medical provider adequate time to review my medical records and make the best decision for my health care.

_____ _____ _____

Signature Printed Name Date

___ I have prescription drug coverage through the following health plan _____
___ I DO NOT have a prescription drug plan medication benefit.

Plan Name: _____
(A copy of your prescription drug card must be provided to the front desk staff of HCI)

You will not be called by our staff.
To check on your refill request.
PLEASE contact your pharmacy.

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MEMBER RIGHTS & RESPONSIBILITIES

Member Rights:

1. You have a right to considerate and respectful treatment, regardless of race, creed, color, sexual orientation, national origin, disability, sex, religious preference, marital status, political beliefs, age or insurance status, in a manner showing dignity and respect regarding your personal values and belief systems.
2. You have a right to be seen at a time as close to your appointment as possible with the understanding that the needs of other patients will also be considered.
3. You have a right to seek care at Community Health Centers (CHC) and your payment will be based upon a sliding fee scale or other program eligibility.
4. You have a right to examine and to receive and explanation of your bill, regardless of the source of payment.
5. You have a right to have all physical examinations, interviews, and discussions take place privately and to have all communications and records about your care handled confidentially.
6. You have a right to know the names and the level of training of the providers who take care of you.
7. You have a right to the understandable explanation of what is wrong with you, the tests and treatments that are planned, and the risks involved in those tests and treatments.
8. You have a right to ask for another CHC provider's opinion or to ask that a new provider take charge of your case on a one-time basis.
9. You have a right to offer concerns or complaints about the health care received. Please ask for the Clinical Team Manager in the center.
10. You have a right to know that CHC does not perform any illegal forms of treatment.
11. You have a right to be informed about your treatment, diagnosis, and prognosis, and to accept or refuse health care advice or treatment.
12. You have a right to plan in advance for your health care and treatment, and to choose someone to make decisions for you, to the extent permitted by law, in case you become unable to make them for yourself.
13. You have a right to be informed of any clinical experimentation or other research/educational projects affecting your treatment and to refuse participation in such a experimentation or research.
14. You have the right to a timely response to your reports of pain and to have a clinically appropriate pain relief plan included in your health care plan.

Member Responsibilities:

1. You are responsible for conduct appropriate in a health care center. You may not verbally or physically abuse CHC personnel or property.
2. You are responsible for keeping your appointment at CHC, or notifying CHC in advance if you are unable to come to your appointment. If your appointment is missed or cancelled with less than 24 hours notice, you will be subject to a $25 no show fee.
3. You have the responsibility to provide accurate proof of your financial situation and to meet program requirements.
4. You have the responsibility to pay your portion of charges at the time of service.
5. You are responsible for questioning your provider about anything you do not understand about your care.
6. You are responsible for giving, to the best of your knowledge, accurate and complete information about complaints, past illnesses, medications, hospitalization and other matters relating to health care.
7. You are responsible for following the instructions given to you by your health care provider. You are responsible for the consequences of your own actions if you fail to follow these instructions, or if you refuse treatment.
8. You are responsible for telling your health care provider when you are in pain and join in your pain relief plan.

Patient Signature	Date	HCI Representative as	Witness Date

My signature above indicates I have read, understand, and will abide by the terms of the Members' Rights and Responsibilities for Healthy Connections, Inc.

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Dental Practice Patient Policies

- We require 24 hours prior notice if you are unable to keep your scheduled appointment. We reserve the right to charge you a No Show fee and/or dismiss you from the practice if you fail to comply.

- Children may **not** be left alone in the waiting room and may **not** accompany you to the treatment rooms/area. Please arrange for child care prior to your appointment or we reserve the right to reschedule your appointment.

- Only patients are allowed in the treatment area/rooms. A parent or guardian may only accompany a patient for treatment if they are special needs or under school age. All patients K-12 a parent or guardian may accompany the patient for their initial exam. The initial exam includes necessary x-rays, hygiene treatment and diagnosis. During this visit the parent/guardian will have the opportunity to meet and discuss treatment findings and options with the treating dentist & hygienist following the initial exam. For all restorative treatment with the dentist, parents/guardians will be asked to remain in the waiting room. If the patient becomes upset the treating dentist or hygienist will request the parent assistance from the waiting room. At any point the parent or guardian has the ability to request to speak with the dentist or hygienist.

- A parent or legal guardian is asked to escort/accompany special needs children and under school age in the treatment areas. Other children are **not** allowed in the treatment rooms while another patient is receiving dental care.

- Patient, legal guardian or nursing home staff **must** remain at the office during treatment if the patient is younger than 18 or is a resident or in the care of a group home, assisted living facility, nursing home, or any other type of guardian care.

- Cell phone use is **not** permitted in the operatories.

- Food and beverage is **not** permitted in the operatories.

- Please be considerate of others when talking. Patients who talk loudly or use inappropriate language may be asked to leave.

I understand and agree to conform to the above dental practice patient polies.

Print Name:_____Date: _____

Patient/Legal Guardian Signature: _____