# Knox Community Health Center (KCHC)
## *ANNUAL REGISTRATION FORM*

***PATIENT INFORMATION***

| NAME (LAST, FIRST, MIDDLE) | PREVIOUS/NICKNAME/AKA | SSN# | BIRTHDATE | SEX (circle one) Male Female |
|---|---|---|---|---|
| | | | | |

***DEMOGRAPHICS***

| PRIMARY ADDRESS (street name and/or P.O. Box) | ETHNICITY (circle one) |
|---|---|
| | a) Hispanic/Latino b) Not Hispanic/Latino c) Unreported or refuse to report |
| **CITY, STATE, ZIP** | **RACE (circle one)** |
| | Asian Native Hawaiian Other Pacific Islander Black/African American White |
| **PRIMARY PHONE NUMBER** / **ALTERNATE PHONE NUMBER** | American Indian/Alaska Native More than one race Unreported or refuse to report |
| *Is it OK for us to leave a message at these numbers? (circle one) Yes No* | |
| **EMAIL ADDRESS** | **Are you a US Military Veteran?** |
| | YES NO |
| **REFERRED BY:** / **PREVIOUS HEALTHCARE PROVIDER:** | **Agricultural Work Status (circle one)** |
| | Non-Agricultural Employed Year-Round Seasonal Migrant Retired Farmer |

**EMERGENCY CONTACT NAME/CONTACT NUMBER OF SOMEONE NOT LIVING IN HOUSEHOLD:** _____ / _____ / _____
Name of Emergency Contact | Relationship to Patient | Contact Phone Number

***INSURANCE***

| GUARANTOR IS PATIENT | GUARANTOR (name on insurance card) | SSN# of Guarantor | BIRTHDATE of Guarantor |
|---|---|---|---|
| *YES NO | | | |
| **GUARANTOR SAME ADDRESS AS PATIENT** | **PRIMARY ADDRESS of Guarantor if different than patient** | **CITY, STATE, ZIP** | |
| *YES NO | | | |

* if YES, proceed to next section

***For our grant purposes only, please note your family size and provide an estimate of your annual household income**

| # Family members in house: | | Total Annual Household Income: | $ |
|---|---|---|---|

☐ **Copy of insurance card(s) attached. If current card(s) obtained/attached, you may skip Primary/Secondary Insurance section.**

***PRIMARY INSURANCE ~ NAME OF INSURANCE COMPANY***

| NAME OF INSURANCE COMPANY | POLICY # / INSURED I.D. | GROUP # |
|---|---|---|
| | | |

| ADDRESS OF INSURANCE COMPANY (street name and/or P.O. Box) | CITY, STATE, ZIP |
|---|---|
| | |

| PHONE # OF INSURANCE COMPANY | EFFECTIVE DATE | NAME OF INSURED | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| | | | |

***SECONDARY INSURANCE ~ NAME OF INSURANCE COMPANY***

| NAME OF INSURANCE COMPANY | POLICY # / INSURED I.D. | GROUP # |
|---|---|---|
| | | |

| ADDRESS OF INSURANCE COMPANY (street name and/or P.O. Box) | CITY, STATE, ZIP |
|---|---|
| | |

| PHONE # OF INSURANCE COMPANY | EFFECTIVE DATE | NAME OF INSURED | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| | | | |

**SLIDING FEE DISCOUNT ~ A sliding fee discount is determined by the hospital by the household size and documented total gross income of the household. A household is defined as one or more individuals who are living together and sharing expenses and income.**

**Do you wish to be evaluated for a discount? YES* NO**
* Income Verification Form to be completed and scanned with income documentation

**I have been offered the KCHC Sliding Fee Discount**

The information related to my income, insurance and identifying data is correct. If I intentionally provide the KCHC with false information, it is considered fraud against the United States Government and could result in denial of future assistance

_____
Signature of Patient (**or Parent or Guardian or Legal Representative) Date

***NOTICE OF PRIVACY AND PATIENT BILL OF RIGHTS***

**I certify that I am 18 years of age or older: YES NO**

**I have been informed of my "Rights to Privacy" and "Patient Bill of Rights" and have received or declined a copy of these patient rights.**

_____
Signature of Patient (**or Parent or Guardian or Legal Representative) Date

***HEALTH INSURANCE AUTHORIZATION***

I hereby authorize the Knox Community Health Center (KCHC) to request payment for services provided for my insurance benefits or health plan benefits payable for services rendered to this patient. I agree that such payments should be made payable to the KCHC. I hereby authorize all attorneys to make direct payment to the KCHC for services rendered to me by the KCHC for any settlement of judgment recovered relating to an accident for which I receive medical treatment. The KCHC may request payment from the following groups which include, but are not limited to, Medicaid, Medicare, Blue Cross/Blue Shield, other insurers, and health maintenance organizations. I agree to pay for all services not covered by these carriers.

Further, I authorize the KCHC to disclose all or any part of the patient's record to any party who may be responsible for all or any part of the patient's charges. I give specific authorization that if my records contain information regarding the diagnosis or treatment of STD's, chemical dependency and mental health conditions, they may be released to the following groups which include, but are not limited to, Medicaid, Medicare, Blue Cross/Blue Shield, other insurers, health maintenance organizations, and workers receiving the information. However, any information already released may be used as stated on this consent. This release of information in limited to the persons or organizations named and does not authorize the recipient to pass the information along to another facility or anyone else.

**I have read the above Health Insurance Authorization, or it has been read to me and I understand its content.**

_____
Signature of Patient (**or Parent, Guardian or Legal Representative) Date

**** If patient is unable to sign:**

_____
Print your name (as the person signing this form _____Date_____
Specify your relationship to the patient: _____
**Do you have legal custody of patient: YES NO**

**KNOX COMMUNITY HEALTH CENTER**
**ACKNOWLEDGEMENT OF OFFICE POLICIES**

Thank you for choosing the Knox Community Health Center (KCHC) for your medical, dental, and behavioral health care needs. Our staff values your time and hopes you will, in return, value ours. In order to serve you better we have the following office policies for you to review and sign. Agreeing to these policies will enable us to provide better care to you in a timely and efficient manner.

1. All patients are required to complete eligibility annually for the Sliding Fee Scale. Fees for the KCHC are based on the patient's household size and income. It is the patient's responsibility to provide current information for this purpose. If information in the patient's chart is expired, the patient will be responsible for full fees until current information is provided.

2. Services rendered are expected to be paid for at the time of service; the KCHC accepts cash, check, or credit cards; payment arrangements should be made in advance of services.

3. Patients must provide the KCHC with a valid photo ID, contact phone number and current address and update this information with staff as necessary.

4. If you are unable to keep a scheduled appointment 24-hour advance notice of cancellation must be provided. Patients arriving more than ten (10) minutes late for their appointment may be asked to reschedule.

5. Patients who are identified as chronic "no shows" will be notified that they are only allowed to schedule the next last available appointment until such time when two consecutive appointments have been kept. During that period, emergency treatment will be provided on a call-in basis only and will have to be approved by the provider.

6. Patients experiencing a need for urgent medical, dental, or behavioral health care may call the KCHC at the beginning of the day and will receive a return call by the end of that day; same day appointments are available afternoons.

7. For patients with insurance coverage, including Illinois Medicaid, eligibility for services will be determined before the start of each visit. You must bring your insurance card and photo identification to each appointment. If eligibility cannot be verified, you may be asked to pay for services or reschedule. Any services not covered by insurance will be your responsibility to pay; unless you have qualified for the Sliding Fee Scale.

8. In most circumstances, minors perform significantly better in the dental chair when parents remain in the waiting room. Therefore, parents will be asked to remain seated in the waiting room. Dental staff will keep you updated on your child's progress during the appointment.

9. Parents and/or guardians bringing a child to a medical, dental, or behavioral health appointment will be expected to stay on the premises during the child's appointment. We regret that we are unable to schedule more than two members from one household on the same day.

10. Although every attempt is made to ensure a very positive experience at the Knox Community Health Center, perfect results cannot be guaranteed. We strive to avoid adverse outcomes, but these cannot be eliminated entirely. Those may include pain, dry socket, allergic reactions, esthetic compromises etc. After treatment patient education and instruction sheets are given to patients that have fillings, extractions etc. ; however, if the pain or reaction goes beyond normal, please call for further instructions, or go to the Emergency Department.

*The Knox County Community Health Center reserves the right to refuse service to verbally or physically abusive patients and/or their parents. These behaviors will be documented and will result in dismissal from the Health Center.*

***I have read and understand the above written policies and hereby agree to abide by them during my care at the Knox Community Health Center. I further understand that if I do not provide the necessary information, I will be expected to pay 100% for all services rendered.***

_____ _____

Signature Date

**ACKNOWLEDGEMENT OF PROVISION**
**OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that, on the undersigned date, I was provided the Notice of Privacy Practices for the Knox County Health Department.

I understand that protected health information will only be disclosed as outlined in the Notice. I may contact the Privacy Officer at the Knox County Health Department if I have any questions.

I may file a complaint with the Health Department as stated in the Notice, and/or request the address of the U.S. Department of Health and Human Services Office of Civil Rights to submit a written complaint, if I feel my privacy rights have been violated. I understand the Knox County Health Department will not retaliate in any way if a complaint is filed.

Patient Name: _____
(Please Print)

Date of Birth: _____

Patient/Guardian Signature: _____ Date_____

Relationship to Patient: _____

**FOR STAFF USE ONLY**

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the Knox County Health Department and was unable to obtain the Acknowledgment because:

___ Client refuses to sign

___ Other_____

Staff member's initials _____

Date_____

# Knox Community Health Center
# Consent for Dental Treatment

**Patient's Name** _____ _____ _____ _____
**First** **MI** **Last** **Date of Birth**

I hereby authorize the Community Health Clinic dentist and staff to perform dental treatment on the above named patient; authorizing them to do whatever they deem advisable if any unforeseen emergency condition arises in the course of treatment, calling, in their judgment, for procedures in addition to or different from those now contemplated.

**I consent to non-emergency treatment after having been advised of the risk, advantages, and disadvantages of the treatments and the consequences if this treatment is withheld, and** consent to the treatment plan after having been advised of the alternative plans of treatment available and the known material risks, advantages, and disadvantages of the alternative treatment.

I further consent to the administration of local anesthesia, antibiotics, analgesics or any other drugs that may be necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g., allergic reactions), cardiac arrest, aspiration, and thrombophlebitis (.e.g., irritation and swelling of the vein) pain, discoloration and injury to blood vessels and nerves, which may be created by injections of any medications or drug.

I am informed and fully understand that inherent in any type of procedure are certain unavoidable complications. In oral procedures, the most common of these complications include post-procedure bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g., numbness in mouth and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restorations and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risk, the contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure.

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and food to which I am allergic. I will follow instructions as explained and directed to me and permit prescribed diagnostic procedures.

**Parent/Guardian Signature** _____ **Date** _____

**Patient Signature** _____ **Date** _____

# Knox Community Health Center
# Consent for Medical/Behavioral Health Treatment

**Patient's Name** _____ _____ _____ _____
**First** **MI** **Last** **Date of Birth**

I hereby authorize the Knox Community Health Clinic to perform medical and/or behavioral health care treatment on the above named patient. I consent to the provision of services and/or surgical care by Knox Community Health Center and its providers and health care personnel providing services at the Knox Community Health Center. Such care may include, but is not limited to, diagnostic and therapeutic tests and procedures and treatment as may be ordered by any provider, and/or his/her designees. I specifically consent to the testing of my blood for infectious diseases of any nature and description including, but not limited to, hepatitis, syphilis, gonorrhea or human immunodeficiency virus (HIV) (causative agent of AIDS), if determined by my attending physician to be necessary in the course of medical treatment: (1) to determine the appropriate treatment for me; or (2) for the protection of the attending physicians and health care personnel caring for me who are exposed to my blood or body fluids.

I understand that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me as to the diagnosis or treatment. I have the right to consent or to refuse consent to any proposed test, medical procedure or therapeutic course of treatment. Any authorization or consent that I give may be canceled or revoked by me in writing at any time. I am aware that physicians, nurses, and other health care personnel who are in training may provide care to me, unless I direct otherwise in writing, such personnel may be present and assist with my care as part of their education.

I agree that I am individually obligated to pay the full charge of all services rendered to me at the Knox Community Health Center if my Payor does not provide benefits for services I receive at the Knox Community Health Center.

I agree that I (or another person who specifically agrees to guarantee payment for me) am responsible for any applicable coinsurance payments and deductibles and all amounts for which my Payor has denied payment with these amounts being due within 10 days of the billing date. Amounts due from me to Knox Community Health Center prior to the execution of this agreement may, at the sole discretion of Knox Community Health Center and may be consolidated with, and made a part of, the amount due hereunder.

I irrevocably authorize direct payment to the Knox Community Health Center of any Payor benefits otherwise payable to or on my behalf for services rendered. I understand that I am financially responsible for charges not covered by my Payor. I authorize Knox Community Health Center to act as attorney-in-fact for the collection of Payor benefits or from any responsible third party through whatever legal means necessary and the endorsement of benefit checks made payable to the patient or me**.**

I have provided as accurate and complete medical and personal history as possible including those antibiotics, drugs, medications, and food to which I am allergic. I will follow instructions as explained and directed to me and permit prescribed diagnostic procedures.

**Parent/Guardian Signature** _____ **Date** _____

**Patient Signature** _____ **Date** _____

# Knox Community Health Center

## Medical History

Are you currently under a physician's care now? ❑ Yes ❑ No If yes, explain: _____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, explain: _____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, explain: _____

Women: Are you,

Pregnant/Trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑Local Anesthetics ❑ Acrylic ❑ Metal ❑Latex
❑ Sulfa Drugs ❑Other If yes, please explain: _____

Please place a check mark in the box next to the items you have, or have had in the past.

| | | | |
|---|---|---|---|
| ❑ Aids/HIV Positive | ❑ Cortisone Medicine | ❑ Hemophilia | ❑ Radiation Treatments |
| ❑ Alzheimer's Disease | ❑ Diabetes | ❑ Hepatitis A | ❑Recent Weight Loss |
| ❑ Anaphylaxis | ❑ Drug Addiction | ❑ Hepatitis B or C | ❑ Renal Dialysis |
| ❑ Anemia | ❑ Easily Winded | ❑ Herpes | ❑ Rheumatic Fever |
| ❑ Angina | ❑ Emphysema | ❑ High Blood Pressure | ❑ Rheumatism |
| ❑ Arthritis/Gout | ❑ Epilepsy or Seizures | ❑ High Cholesterol | ❑ Scarlet Fever |
| ❑ Artificial Heart Valve | ❑ Excessive Bleeding | ❑ Hives or Rash | ❑ Shingles |
| ❑ Artificial Joint | ❑ Excessive Thirst | ❑ Hypoglycemia | ❑ Sickle Cell Disease |
| ❑ Asthma | ❑ Fainting spells/dizziness | ❑ Irregular Heartbeat | ❑ Sinus Trouble |
| ❑ Blood Disease | ❑ Frequent Cough | ❑ Kidney Problems | ❑ Spina Bifida |
| ❑ Blood Transfusion | ❑ Frequent Diarrhea | ❑ Leukemia | ❑ Stomach/Intestinal Disease |
| ❑ Breathing problem | ❑ Frequent Headaches | ❑ Liver Disease | ❑ Stroke |
| ❑ Bruise Easily | ❑ Genital Herpes | ❑ Low Blood Pressure | ❑ Swelling of limbs |
| ❑ Cancer | ❑ Glaucoma | ❑ Lung Disease | ❑ Thyroid Disease |
| ❑ Chemotherapy | ❑ Hay Fever | ❑ Mitral Valve Prolapse | ❑ Tonsillitis |
| ❑ Chest Pains | ❑ Heart Attack/Failure | ❑ Osteoporosis | ❑ Tuberculosis |
| ❑ Cold Sores/Fever Blisters | ❑ Heart murmur | ❑ Pain in Jaw Joints | ❑Tumors or Growths |
| ❑Congenital Heart Disorder | ❑ Heart Pacemaker | ❑ Parathyroid Disease | ❑Ulcers |
| ❑ Convulsions | ❑ Heart Trouble/Disease | ❑ Psychiatric Care | ❑Venereal Disease |
| | | | ❑Yellow Jaundice |

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain

_____

## Please list ALL past surgeries:

_____ _____

_____ _____

_____ _____

_____ _____

# Knox Community Health Center

## Please list ALL Current Medications & Dosage

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Please list ALL Allergies

## Family Medical History

Mother: _____

Father: _____

Siblings: _____

Other: _____

## Social History

**Marital Status**: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

**Occupation**(s):

(PLEASE BE SPECIFIC ABOUT ANY OCCUPATIONS WHERE YOU MAY HAVE BEEN EXPOSED TO HAZARDOUS MATERIALS)

_____

_____

**Tobacco:**

❑ Current, Ever Day ❑ Current, Some days ❑ Former ❑ New Smoker

Amount Used: _____ Age Start: _____ Age Stop: _____

**Alcohol Consumption (type and amount):**

Amount Used/Frequency: _____

Type: ❑ Beer ❑ Wine ❑ Liquor ❑ Multiple

**Drug Use:**

_____

_____

## Patient Signature

Please sign and date this form to verify all the above

_____ _____

Signature Date

Last revised 3/3/2015