Patient Registration

☐ I need a hearing interpreter ☐ I need a language interpreter

Patient Info Date:

First Name | Middle Initial | Last Name

Date of Birth | Social Security# | Occupation

Address | Apt# | PO Box

City | State | Zip Code | County

Primary Phone | Secondary Phone | Email

Emergency contact (not living in your household):

First Name | Last Name | Phone# | Relationship to patient

Does the patient reside in a nursing home or residential care facility ?

☐ Yes ☐ No If Yes, Where? Phone#

Access Family Care participates in federal programs that require us to request the following:

Race
- ☐ American Indian/Alaska native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ Declined

Ethnicity
- ☐ Hispanic/Latino (Cuba,Mexico,Puerto Rico,Central America)
- ☐ Not Hispanic/Latino
- ☐ State Prohibited
- ☐ Declined
- ☐ More than one race

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other:

Marital Status
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Child

Homeless?
- ☐ Yes
- ☐ No

Are you an agricultural worker? ☐ Yes ☐ NO

Veteran Status
- ☐ Not a Veteran
- ☐ Veteran

Sex at birth
- ☐ Male ☐ Female

Sexual Orientation
- ☐ Lesbian,Gay,Homosexual
- ☐ Straight/Heterosexual
- ☐ Bisexual
- ☐ Don't Know
- ☐ Something else
- ☐ Choose not to disclose

#Adults in household_____

#Children in household _____

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Female to Male
- ☐ Male to Female
- ☐ Other
- ☐ Declined

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

Guarantor -person responsible for payment (Complete only if responsible party is not the patient)

First Name | Middle Initial | Last Name

Date of Birth | Social Security# | Employer

Address (If different from the patient) | PO Box

City | State | Zip | Email

Primary Phone | Relationship to patient

Insurance: ☐ Medicaid ☐ Medicare ☐ Commercial ☐ Other_____

CONSENT FORM

Patient Name: Patient Date of birth: Date:

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

Please initial each line:

_____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 including but not limited to Medical, Dental, and Behavioral Health providers.

_____I understand that 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. I 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 Patient Rights. I understand it is my responsibility to read and follow the information contained in this notice.

_____I have received a copy of the Notice of Privacy Practices. I understand that it is my responsibility to read this notice and ask any questions that I may have.

_____I have received a copy of the ACCESS Family Care No-Show Patient Agreement. I understand that attendance issues may cause me to be 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 of ACCESS Family Care.

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

I give my permission to discuss with the individual that I have listed:

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

Name	Relationship	Phone#	Name	Relationship	Phone#
Name	Relationship	Phone#	Name	Relationship	Phone#

Consent to Treat Minor Patient for Medical or Dental Treatment

I, _____authorize the following designated individuals to consent for ☐ Medical ☐ Dental treatment for my child_____. In the event of my absence at the time of injury, illness, or routine scheduled care, I also authorize the below named person(s)to make decisions involving my child's care and to sign necessary documents should my child require hospitalization in case of emergency. I(we) accept financial responsibility for all charges related to any medical/dental treatment or hospitalization rendered by reason of this authorization. This consent does not apply to dental procedures that require Extraction, Nitrous Oxide, or Endodontic treatment(Root Canals). A parent or legal guardian must be present for these procedures. This authorization shall be in effect for 1 year or until_____.

Appointed Agent/Relationship	Phone#	Appointed Agent/Relationship	Phone#
Appointed Agent/Relationship	Phone#	Appointed Agent/Relationship	Phone#

Signature of Responsible Party/legal guardian Date Signature of ACCESS Family Care Staff

APPLICATION FOR FINANCIAL ASSISTANCE

ACCESS FAMILY CARE

Date:

SECTION I

(Patient First Name) (Patient Middle Initial) (Patient Last Name) Patient Birth Date(mm/dd/yyyy)

Applicant Name (First, Middle initial, Last) Applicant date of birth(mm/dd/yy) Applicant relation to patient

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow

Spouse Name

Federal Grant Guidelines require us to exhaust 3rd Party payer sources before applying the Slide Discount Fee

SECTION II HOUSEHOLD INFORMATION

Please list everyone living in your home (including yourself) **that this income supports**, and anyone whom you claim as a dependent on your federal income tax return.

*Non-related adults should be listed if they contribute to the household income(food/rent/utilities).

*Adults (**except for your Spouse**) listed below with zero income must provide required documentation.

Name	**Age**	**Relationship to Applicant**	**Source of Income** Wages, Social Security,etc...	**How often are you paid?** (Every week, Every other week, 1 time per month, 2

Please include income documentation for each ADULT listed above.

☐ # of household members this income supports $ ☐ Total estimated gross annual income

SECTION III INSURANCE

Do you or the patient have medical/dental insurance? ☐ YES ☐ NO

If YES, Please provide a copy of the front and back of your insurance card(s) to the front desk.

SECTION IV ZERO INCOME DOCUMENTATION

You must provide ONE of the options listed below for Zero income documentation:

A. Notarized Letter: A letter from the person or facility where you are currently staying stating that they are providing for your basic needs(food/shelter/clothing) and that you don't currently have a source of income. The letter must be NOTARIZED, dated within the past 30 days, signed, and include the contact information(address and phone #) of the person who wrote the letter.

**Adults other than spouse(18 years or over) who live in the home and whom you claim as dependents and/or occupants are also required to provide a notarized letter stating that you provide for their basic needs as stated above.

**By providing this information, you are giving us permission to contact this person for verification of the zero income status. Please check with the front desk staff if you need assistance obtaining the services of a notary.

B. Income verification from Family Services: If you are receiving food stamps or Temporary assistance for needy families(TANF), a copy of the income verification or statement from the Family Services office will serve as proof of income.

SECTION V APPLICANT AFFIDAVIT

I certify that the information on this application is true and accurate. I understand that it is my responsibility to complete the application and provide the required proof of income documentation in order to apply for discounted services. I understand that if I do not provide the required income documentation on my initial visit, I will be responsible for the full charges. I understand I have 30 days from my initial date of service to provide the required income documentation and receive a discount if I qualify and that no discount will be applied to accounts older than 30 days. I agree to inform Access Family Care if my financial situation changes significantly. I also understand that falsifying information or documentation on this application will result in my application being denied and any applicable discounts received under false pretenses will be revoked and I will be responsible for all charges. I understand that this application and any discount that I may qualify for apply only to the patient listed on this application. Any/all additional patients would need to apply separately.

PRINT NAME OF APPLICANT

SIGNATURE OF APPLICANT/ DATE

Medical and Dental History

Patient Name (First, MI, Last) | Patient Date of Birth | Date

Occupation | Employer | Marital Status | Physician name

Reason for visit today: | Are you in pain? ☐ Yes ☐ No

Personal Medical History (Please check all that apply):			
☐ ADD/ADHD	☐ Coronary Artery Disease	☐ Chemotherapy/Radiation	☐ Thyroid Disease
☐ Anxiety	☐ Heart Attack	☐ Radiation to head/neck	☐ Cold sores/fever blister
☐ Autism/Asperger's	☐ Heart Murmur/Irregular heart beat	☐ Trauma to head/neck	☐ Hepatitis
☐ Bipolar Disorder	☐ Heart trouble/disease	☐ Vision problems	☐ Herpes
☐ Cognitively/ Developmentally Disabled	☐ High Blood Pressure	☐ Migraines	☐ HIV
☐ Depression	☐ High Cholesterol	☐ Malignant Hyperthermia	☐ MRSA infection
☐ Psychiatric Care	☐ History of endocarditis	☐ Hearing problems	☐ Sexually Transmitted Diseases
☐ Anemia	☐ Mitral valve prolapse	☐ Dizziness/Fainting	☐ Tuberculosis
☐ Blood Clots	☐ COPD	☐ Convulsions/ Epilepsy/Seizure Disorder	☐ Chronic abdominal issues
☐ Bruise easily/excessive bleeding	☐ Stroke	☐ Cerebral Palsy	☐ Gallbladder disease
☐ Artificial heart valve	☐ Aneurysm	☐ Cortisone/Steroid medicine	☐ Heartburn
☐ Atrial Fibrillation	☐ Kidney Disease	☐ Diabetes	☐ Liver disease
☐ Chest Pain	☐ Cancer Type:	☐ Osteoporosis	☐ Stomach Ulcer
		☐ Taken or taking bone density medication	☐ Other: (list below)

Surgical History (Please check all that apply and list the date):			
☐ Angioplasty/ Cardiac bypass Type: Date:	☐ Pacemaker Date:	☐ History of general anesthesia problems Date:	☐ Joint replacement Type: Date:
☐ Heart stent Date:	☐ Other heart surgery Type: Date:	☐ Appendectomy Date:	☐ Ear, Nose, Throat Type: Date:
☐ Heart valve Date:	☐ Vascular Surgery Date:	☐ Hysterectomy Date:	☐ Gall bladder Date:

Please list any additional surgeries and dates:

List any recent hospitalizations including reason and date:

Would you like information about creating an Advanced Directive? ☐ Yes ☐ No

Medical and Dental History

Patient Name | Patient Date of Birth | Date

Medications/Herbal supplements	☐ **No Medications**
1.	5.
2.	6.
3.	7.
4.	8.
Allergies	☐ **No Known Allergies**
1.	4.
2.	5.
3.	6.

Family History -Check if your blood relatives have had any of the following:

☐ Heart Disease	☐ Stroke	☐ Cancer	☐ Depression/Suicide
☐ Cholesterol	☐ Bleeding/Clotting	☐ Asthma/COPD	☐ Mental health issues
☐ High Blood Pressure	☐ Diabetes	☐ Alcoholism	☐ Inherited disorders
☐ Other: (Please list)			

Social History

Do you use tobacco? ☐ Yes ☐ No Type: Amount/day: How long? Year quit:

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week?

Have you ever used illegal drugs? ☐ No ☐ Yes, used in the past ☐ Yes, currently use

Women's Health History (Dental patients only need to answer questions indicated with *)

Please list the number of: Pregnancies: Live deliveries: Live Children:

Miscarriages: Abortions:

Are you Menopausal/Post-Menopausal? ☐ Yes ☐ No If yes, please provide the age of onset: _____

Date of last menstrual period: _____ Date of last mammogram:_____

Date of last pap smear: _____ Result of pap smear? ☐ Normal ☐ Abnormal

*Are you currently pregnant? ☐ Yes ☐ No Due date? * Are you currently nursing? ☐ Yes ☐ No

Birth/Pediatric History

Maternal illness/complications? ☐ Yes ☐ No Stayed in NICU? ☐ Yes ☐ No

Premature birth? ☐ Yes ☐ No If yes, how early?_____ Feeding History: ☐ Breast ☐ Bottle ☐ Both

Birth Weight lbs. oz. Immunizations up to date? ☐ Yes ☐ No

Dental History

Reason for dental visit today:

Date of last dental visit: Name of Dentist:

Has a doctor ever advised you to take antibiotics before a dental procedure other than for a dental infection? ☐ Yes ☐ No

Are you wearing removable dental appliances? ☐ Yes ☐ No

Do you have any fears or serious trouble related to your last dental visit? ☐ Yes ☐ No

If yes, please explain:

I certify that to the best of my knowledge, the questions on this form have been answered accurately and that providing false or incorrect information can be detrimental to my(or patient's)health. I understand it is my responsibility to inform the medical office of any changes to my health or medical history. I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

PRINT NAME | Signature | Date

No-Show Patient Policy Agreement

The goal of ACCESS Family Care is to assure that our patients have access to high quality medical and dental care when they need it. The purpose of this agreement is to inform you of requirements which have been established as regards your appointments for care at ACCESS medical and dental clinics as follows:

- **You must provide us with a working telephone number and you must inform us if that number changes.**
- **Reminder of Appointment – Although you are ultimately responsible for remembering your appointment date and time, we will call you one to two business days before your appointment to remind you.**
- **Confirming Appointment – If we are unable to speak with you and must leave a voicemail message for you, we request that you call us as soon as possible to confirm your intent to keep your appointment. If you fail to confirm your appointment, it may be given to another patient, so that if you show up for the appointment without having confirmed, we would not be able to accommodate you and you would need to reschedule.**
- **Failure to Keep an Appointment – If you fail to keep an appointment which has been made for you, it will be considered a missed appointment.**
- **Canceling Appointments - If you cannot keep your scheduled appointment, you must contact us at least 24 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice of cancelation counts as a missed appointment.**
- **Late Appointments - If you show up more than 10 minutes late for your appointment, it will be considered a missed appointment. Your appointment may have been given to a waiting patient, in which case you may be required to reschedule, or have to wait to be seen.**
- **Consequences of Missed Appointments – If within the same 12-month interval you have three (3) missed appointments, either failing to keep an appointment, canceling with less than 24 hours' notice, or showing up more than 10 minutes late, or any combination thereof, your attending practitioner will be notified. That practitioner, in consultation with the Medical or Dental Director, will make a decision regarding whether or not you will be dismissed as a patient. If the decision is made to dismiss you as a patient, you will receive notification by Registered Mail that you have been permanently dismissed as a patient from all ACCESS Family Care Medical and Dental Clinics.**

Please speak to any of the clinic staff if you have questions about this No-Show Patient Policy Agreement.

I have read, understand and agree to abide by this No-Show Patient Policy Agreement:

_____ _____

Patient Name (PLEASE PRINT NAME) Date

_____ _____

Parent/Guardian (for patients under 18) / Patient Signature Date

El objetivo de ACCESS Family Care es asegurarse de que nuestros pacientes tengan una atención médica y dental de alta calidad cuando ellos lo necesiten. El propósito de este Acuerdo es informarle de los requisitos que se han establecido para su cita en las clínicas de ACCESS Médica y Dental de la siguiente manera:

- **Usted deberá proporcionarnos un número de teléfono que funcione y deberá informarnos si cambia ese número.**

- **Recordatorio de Citas – Aunque Usted es el único responsable de recordar el día y la hora de su cita, nosotros le llamaremos uno o dos días laborales antes para recordarle de su cita.**

- **Confirmación de Citas – Si no podemos hablar con Usted y tenemos que dejarle un mensaje de voz, le pediremos que nos llame tan pronto como le sea posible para confirmar si vendrá o no a su cita. Si Usted no confirma su cita, ésta será dada a otro paciente y si Usted se presenta sin haber confirmado su cita, nosotros no podremos atenderlo y usted necesitará reprogramar otra cita.**

- **Faltar a una Cita – Si Usted no acude a la cita que se le ha hecho, será considerada como una cita perdida.**

- **Cancelación de Citas – Si no puede acudir a su cita programada, deberá ponerse en contacto con nosotros por lo menos 24 horas antes de su cita para que podamos ofrecer esa cita a otro paciente. Si Usted no llama 24 horas antes de su cita, contará como una cita perdida.**

- **Retraso de Citas – Si Usted se presenta más de 10 minutos tarde de su cita, será considerada como una cita perdida. Su cita se le dará a un Paciente en espera, y en ese caso a Usted se le pedirá que programe otra cita o tenga que esperar para ser visto.**

- **Consecuencias de Citas Perdidas – Si en un intervalo de 12 meses tiene tres (3) citas perdidas, ya sea que no haya acudido a su cita, cancelado por lo menos con 24 horas de anticipación, o haber llegado más de 10 minutos tarde a su cita, o cualquier combinación de ellos, ésto se le notificará al Médico que lo atiende. El Médico consultará con el Director Médico o Dental, tomarán una decisión sobre sí o no será despedido como paciente. Si se ha tomado la decisión de despedirlo como paciente, Usted recibirá una notificación por Correo Certificado de que Usted ha sido permanentemente despedido como Paciente de todas las Clínicas de ACCESS Family Care Médica y Dental.**

Por favor póngase en contacto con cualquier persona de la Clínica si tiene alguna pregunta relacionada con este Acuerdo de la Política del Paciente por no Presentarse.

He leído, entiendo y acepto cumplir con este Acuerdo de la Política del Paciente por no presentarse.

_____ _____

Nombre del Paciente (Por favor escriba el nombre) Fecha

_____ _____

Firma del Paciente o Padre/Tutor (pacientes menores de 18) Fecha

New Patient Survey

Clinic: ❒ Anderson ❒ Cassville ❒ Joplin ❒ Neosho ❒ Mt. Vernon ❒ Lamar ❒ Carthage ❒ Nevada

Appointment type: ❒ Medical ❒ Dental

How did you hear about our clinic? Please check all that apply.

❒ TV ❒ Health Department ❒ Newspaper ❒ Friend/Family ❒ Church ❒ Radio

❒ Internet ❒ Ozark Center ❒ Phone Book ❒ Community Clinic ❒ Employer

❒ Certified Application Counselor Event ❒ Social media (Facebook, Twitter): _____

❒ Local Agency (such as Planned Parenthood, ESC, WIC, Family Services): _____

❒ Head Start: (which center) _____ ❒ School: (please name) _____

❒ Hospital: (please name) _____ ❒ ACCESS Employee: (please name) _____

❒ Community Event: (please name) _____ ❒ Other: _____

❒ Became a patient because ACCESS-Joplin has pharmacy services

Revised 9/2016

Encuesta de Pacientes Nuevos

Clínica: ❒ Anderson ❒ Cassville ❒ Joplin ❒ Neosho ❒ Mt. Vernon ❒ Lamar ❒ Carthage ❒ Nevada

Tipo de Cita: ❒ Médica ❒ Dental

Como se enteró de nuestra Clínica? Por favor marque todas las que aplican.

❒ TV ❒ Departamento de Salud ❒ Periódico ❒ Amigo/Familia ❒ Iglesia ❒ Radio

❒ Internet ❒ Ozark Center ❒ Directorio Telefónico ❒ Community Clinic ❒ Empresa

❒ Consejero Certificado de Eventos ❒ Medios Sociales (Facebook, Twitter): _____

❒ Agencia Local (como Planned Parenthood, ESC, WIC, Family Services): _____

❒ Head Start: (cuál Centro) _____ ❒ Escuela: (nombre) _____

❒ Hospital: (please name) _____ ❒ Empleado de ACCESS:(nombre)_____

❒ Evento Comunitario: (nombre) _____ ❒ Otro: _____

❒ Se hizo paciente porque ACCESS-Joplin tiene servicios de Farmacia.

Revised 9/2016