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
- ☐ White
- ☐ Asian
- ☐ American Indian/Alaska native
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Decline to answer/Unknown

Ethnicity
- ☐ Not Hispanic/Latino
- ☐ Hispanic/Latino
- ☐ Unknown/Decline to answer

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Child

Homeless?
- ☐ Yes
- ☐ No

Veteran Status
- ☐ Not a Veteran
- ☐ Veteran

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

#Adults in household_____

#Children in household _____

Are you an agricultural worker? ☐ Yes ☐ No

Gender Identity
- ☐ Male
- ☐ 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 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, _____am the parent of the patient and 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_____.

☐ I_____affirm that I am the step-parent of the patient, am married to the natural parent and live with the natural parent and child, and am able to consent for the child's medical/dental treatment.

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

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.

Final Signature (Applies to all consents)

X

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

ACCESS FAMILY CARE

APPLICATION FOR FINANCIAL ASSISTANCE

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/month, 2 times/month, other)

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 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 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 History

Patient Name | Patient Date of Birth | Date

Medications/Herbal supplements	☐ **No Medications**
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies	☐ **No Known Allergies**
1.	5.
2.	6.
3.	7.
4.	8.

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

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

DENTAL HISTORY FORM Please answer all questions. Please print.

Patient Name: _____ Date of birth: _____/_____/_____
LAST FIRST MI Today's Date:_____/_____/_____

Dental Information-

Reason for dental visit today: _____

Date of last dental visit: _____Name of dentist: _____

Do you have any dental fears or anxieties related to previous dental experiences? YES NO

If YES, please explain? _____

Are you currently or have you ever experienced any of the following: □ Tenderness □ Sore areas in mouth
□ Bleeding gums □ Pain in or near ears □ Bad breath □ Sensitivity to hot, cold, or sweets

On a scale of 1 – 10, circle your pain level. No Pain Low 1 2 3 4 5 6 7 8 9 10 High

Are you wearing removable dental appliances? YES NO

Medical Information-

ALLERGIES: Are you allergic to or had a reaction to any of the following? If Yes, please list what type of reaction on the line provided (rash, welts, etc.)

Aspirin, Motrin (Ibuprofen) YES NO _____ Latex YES NO _____
Local Anesthetics YES NO _____ Codeine or other Narcotic YES NO _____
Acrylic YES NO _____ Metals YES NO _____
Penicillin, Keflex (Cephalexin), or other antibiotic YES NO _____ If yes, specify which antibiotic _____
Other allergies (please list)_____

MEDICATIONS: Please list all medications, including non-prescription medications:

Name of medication	Amount/dosage	Frequency (how often)	Prescribed by Dr. name	Reason for medication

Do you smoke? YES NO Do you use chewing tobacco? YES NO
Do you currently or have you ever used controlled substances (drugs)? YES NO Are you in good health? YES NO
Has there been any change in your general health within the past year? YES NO
Are you under the care of a physician? YES NO If YES, what is the condition being treated? _____
The name and telephone number of the physician: _____
Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO
If YES, please detail the operation or illness: _____
_____
_____

1. Has a medical doctor ever advised you to take antibiotics before a dental procedure "because of something other than a dental infection?" YES NO
   If yes, please specify _____

2. Are you taking any blood thinners? Yes No If so, please indicate below:
   □ Eliquis (Apixaban) □ Xarelto (Rivaroxaban) □ Pradaxa (Dabigatran) □ Heparin (Hemochron) □ Coumadin (Warfarin)
   □ Plavix (Clopidogrel Bisulfate) □ Other_____
3. Are you taking or have you been advised to take prescription medication for bone disease? YES NO
   a. If YES, are you currently or have you ever taken one of the following medications?
      □ Actonel (Risedronate) □ Boniva (Ibandronate) □ Fosamax or Fosamax Plus D (Alendronate)
      □ Skelid (Tiludronate) □ Didronel (Etidronate) □ Prolia (Denosumab)
      □ Xgeva (Denosumab) □ Other _____
4. Have you ever been administered any of the following drugs intravenously (I.V.) for the treatment of cancer?
   □ Aredia (Pamidronate) □ Zometa or Reclast (Zolendronic Acid) □ Benefos (Clodronate)
5. Do you have any artificial joints? YES NO If Yes, Location _____ Date Placed _____
6. Have you received Chemotherapy or Radiation Therapy for cancer or other disease? YES NO

Women

7. Are you or could you be pregnant? YES NO If YES, what is your due date? _____
8. Are you nursing? YES NO Are you taking birth control pills or hormone replacement? YES NO

Do you have or have you had any of the following diseases or conditions? Please circle the appropriate answer.

Unexplained fever	Yes	No	Shortness of Breath	Yes	No	Hepatitis B	Yes	No
Unexplained weight loss	Yes	No	Tuberculosis	Yes	No	Hepatitis C	Yes	No
Head Injury	Yes	No	Heart Trouble/Heart Attack	Yes	No	Stroke	Yes	No
Kidney Disease	Yes	No	Date _____			Date _____		
Cancer/Tumors	Yes	No	Mental Disorder	Yes	No	Venereal Disease	Yes	No
Type _____			Type _____			Type _____		
Congenital Heart Disease	Yes	No	Epilepsy/Seizures	Yes	No	Nervous Disorder	Yes	No
Repair Date _____			Angina/Coronary Insufficiency	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Chest Pain upon Exertion	Yes	No	Arthritis/Rheumatism	Yes	No
Hypoglycemia	Yes	No	Glaucoma	Yes	No	Damaged or Artificial Heart Valves	Yes	No
Fainting/Dizzy Spells	Yes	No	Sinus Problems	Yes	No	Rheumatic Fever	Yes	No
Cardiac Pacemaker	Yes	No	Cortisone Injections	Yes	No	AIDS / HIV	Yes	No
Cold Sores/Fever Blisters	Yes	No	Ulcers	Yes	No	Blood or Bleeding Disorder	Yes	No
Thyroid Disease	Yes	No	Liver Disease	Yes	No	Blood Transfusion	Yes	No
Respiratory Problems	Yes	No	Jaundice	Yes	No	Malignant Hyperthermia	Yes	No
Asthma	Yes	No	Hepatitis A	Yes	No			

Explain any YES answers: _____

_____

_____

Do you have any other medical problems or concerns? YES NO _____

_____

Name of person completing this form: _____ Relationship to patient: _____

I certify to the best of my knowledge, the questions on this form have been answered accurately. I understand that providing false or Incorrect information can be detrimental to my (or patient's) health. I understand it is my responsibility to inform the dental office of any changes in my health or medical history. I will not hold my dentist 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

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 regarding 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 may not be able to accommodate you and you would need to reschedule or wait to be seen.**

- **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.**

- **Cancelling 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 cancellation counts as a missed appointment.**

- **Late Appointments-If you show up more than 10 minutes late for your appointment, it may 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, cancelling with less than 24 hours' notice, 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

HEALTH INFORMATION EXCHANGE
PATIENT INFORMATION

ACCESS Family Care participates in a health information exchange so that your care providers can access your electronic health records from other health care providers. This form provides information on Midwest Health Connection and how AFC shares your records with the health information network so your care provider can share and access your electronic health records so that your care team can make the best care decisions for you. Your health records exist in many places. MHC connects your providers, hospitals and labs to each other. With a more complete picture of your health, your health care team can take better care of you In the doctor's office, hospital or emergency room. You won't have to collect records from different providers or remember lab and medication history, it will be available to your care team 24/7.

Who has access to the MHC Network?
Only health care professionals, health plans, and other authorized recipients will have access to your medical records, to the extent permitted by law, including for treatment, payment, and healthcare operations purposes. Medical record information is protected by federal and state law and records shared with a health information exchange will comply with those laws. You can ask ACCESS Family Care staff for a list of health care providers who have seen your records or accessed them from the health information exchange.

Please read the statements below:

- ACCESS Family Care may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, health care operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs.

- The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information and test results; genetic information and test results; STD treatment and test results, and family planning information.

- The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. If you would like to opt-out of the health information exchange, please ask an AFC staff member for an opt-out form.

- If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).

- Current law allows my providers who are treating me to copy or include my health data in their own medical records. Even if I later cancel my consent, providers I've visited who have copied my records are not required to remove them.

- The health information exchange will keep track of who views my health records to make sure they are secure.

- AFC has penalties in place for anyone sharing my data in the wrong way and if I suspect or learn that my data was shared or accessed the wrong way, I may contact ACCESS Family Care at 417-451-0619 and ask to speak with the Privacy Officer.

- More information on Midwest Health Connection can be found at https://www.mhc-hie.org/