SEMO HEALTH NETWORK

Patient Name: _____

Date of Birth: _____ /_____ /_____ Today's Date: _____

HEALTH HISTORY FORM

Name of physician: _____ City: _____

Date of last exam: _____ Reason: _____

Please list any medications, over-the-counter drugs, or supplements you take:

_____

_____

_____

Please circle any allergies or adverse reactions:

Amoxicillin/Penicillin Codeine Latex Local Anesthetic Iodine Metals Sulfa

Dental Materials Aspirin Other: _____

General Health

Please Check:	Yes	No	Don't Know
Are you in good health?	❑	❑	❑
Have there been any changes to your health in the last year?	❑	❑	❑
Have you had any serious illness, operation, or been hospitalized in the past five years?	❑	❑	❑

If yes, describe: _____

_____

Please Check:	Yes	No	Don't Know
Have you had a total joint replacement?	❑	❑	❑

If yes, when? _____

What joint? _____

Has a doctor ever told you to take antibiotics before dental treatment?	❑	❑	❑
Have you ever taken IV bisphosphonates? (Examples: Boniva, Fosamax, alendronate)	❑	❑	❑

Women Only:

Are you or could you be pregnant?	❑	❑	❑
Are you breast-feeding?	❑	❑	❑

Review of Systems:

Please mark all that apply.

Please Check:	Yes	No	Don't Know
Abnormal Bleeding	❑	❑	❑
AIDS or HIV Infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑

(circle) Osteoarthritis or Rheumatoid arthritis

Blood Transfusion	❑	❑	❑

If yes, date: _____

Cancer	❑	❑	❑

If yes, site: _____

Chemotherapy or radiation	❑	❑	❑

Review of Systems:

Please mark all that apply.

Cardiovascular disease:

If **yes,** specify below by marking with an **X**:

___ High blood pressure ___ Low blood pressure

___ Angina ___ Heart Murmur

___ Artificial heart valves ___ Heart attack

___ Mitral valve prolapse ___ Atherosclerosis

___ Rheumatic fever ___ Pacemaker

___ Arteriosclerosis ___ Irregular heart beat

___ Congestive heart failure

Please Check:	Yes	No	Don't Know
Diabetes	❑	❑	❑

Please specify: Type I ___ or Type II ___

Eating Disorder	❑	❑	❑
Epilepsy/Seizures	❑	❑	❑
Glaucoma	❑	❑	❑
Hemophilia	❑	❑	❑
Hepatitis	❑	❑	❑

Type (circle): A B C

Kidney problems	❑	❑	❑
Neurologic disorders	❑	❑	❑
Organ transplant	❑	❑	❑
Osteoporosis/osteopenia	❑	❑	❑
Sinus trouble	❑	❑	❑
Sexual transmitted disease	❑	❑	❑
Steroid therapy	❑	❑	❑
Stroke	❑	❑	❑
Thyroid disease	❑	❑	❑
Tuberculosis	❑	❑	❑
Ulcers	❑	❑	❑

Other condition not listed: _____

Mental and Developmental Health

Please Check:	Yes	No	Don't Know
Anxiety	❑	❑	❑
ADD/ADHD	❑	❑	❑
Autism	❑	❑	❑
Depression	❑	❑	❑

Mental, behavioral, developmental condition not specified: _____

SEMO HEALTH NETWORK

Patient Name: _____

Date of Birth: _____ /_____ /_____ Today's Date: _____

DENTAL AND LIFESTYLE HISTORY FORM

Lifestyle

Do you have any physical or mental disabilities that may require special care such as hearing, sight, or speech impairments? If yes, please describe:

_____

Do you drink alcohol? (Circle) Yes No

Please list amount and frequency: _____

Do you smoke or use tobacco? (Circle) Yes No

Please list type and amount: _____

Do you use any street drugs? (Circle) Yes No

Please list type: _____

Dental History

What is your reason for seeking care today?

_____

_____

Do you have regular dental check-ups? ❑ Yes ❑ No

Date of last dental exam: _____

Date of last dental x-rays: _____

Have you had any trouble with previous dental treatment? ❑ Yes (Explain below) ❑ No

_____

_____

How do you care for your teeth?

_____

	Yes	No	Don't Know
Has fear ever prevented you from seeking dental care?	❑	❑	❑
Do your gums bleed when you brush your teeth?	❑	❑	❑
Do you have lumps or sores in your mouth?	❑	❑	❑
Do you suffer from pain in the mouth, face, eyes, neck, or throat?	❑	❑	❑
Do you ever have pain, clicking, or popping in your jaw (TMJ)?	❑	❑	❑
Are you happy with the appearance of your teeth?	❑	❑	❑
Do you want to save your teeth?	❑	❑	❑
Do you feel that you have dry mouth?	❑	❑	❑
Do you eat or drink sugary foods or drinks?	❑	❑	❑
Have you ever injured your face, jaws, or teeth?	❑	❑	❑

Please check any dental treatment you have received in the past:

❑ Fillings	❑ Orthodontics (braces)	❑ Oral Surgery (extractions)	❑ Gum treatment
❑ Root canals	❑ Dentures	❑ Implants	❑ TMJ treatment

Do you have any other concerns, conditions, or comments not addressed?

_____

I affirm that this record is true and accurate to the best of my knowledge (Check: ❑Self ❑Parent/Guardian)

X_____ _____

Signature Date

Southeast Missouri Health Network
Patient Registration

Patient Information

Last Name:_____ First Name:_____MI:_____

DOB:_____ SSN:_____ Gender: M F

Street Address:_____ PO BOX:_____

City:_____ State:_____ County:_____ ZIP:_____

Home Phone:(_____)_____ Cell:(____)_____ Work Phone: (_____)_____

Marital Status: ___Single ___Married ___Divorced ____Separated ___ Widowed

Email address:_____ Pharmacy:_____

Employment Status: ____Full Time ____Part-Time ____None ____Student

Employer:_____ Address:_____

Race: ____White ____American Indian ____Black ____Pacific Islander ____Asian ____Native Hawaiian Other_____ ____More than 1 race	Ethnic Background: _____Hispanic or Latino _____Non-Hispanic or Latino _____Unknown
Language best served in: ____English ____German ____Japanese ____Chinese ____Italian ____Sign Language ____French ____Spanish ____Other_____	
Housing Status: ____Not Homeless ____Doubling Up ____Transitional ____Homeless Shelter ____Street ____Unknown ____Other_____	

Do you do agricultural work? ___Yes ___No (If yes answer questions below)
Over the past 24 months have you:
1. Been hired to do agricultural work as your main source of income?____Yes ____No
2. Established temporary residence in order to do agricultural work?____Yes ____No
3. Derived over 1/2 of your income from agricultural work?____Yes ____No

Agricultural Status:
____Not Agricultural Worker
____Migrant Worker
____Dependant of Migrant Worker
____Seasonal Worker
____Dependant of Seasonal Worker

Are you a United States citizen? _____ Yes _____ No
Are you a veteran? _____ Yes _____ No

How would you like to receive your reminder for future appointments? Call___ Text___ E-mail___

Responsible Party

If child please list parent/guardian information below:

Parent/Guardian Name:_____

Address:_____

DOB:_____ SSN:_____

Home Phone:(_____)_____ Work Phone:(_____)_____

Employed by:_____Address:_____

Billing Information

Please check below any coverage you may have:

Insurance _____ Medicaid: _____ Applying For Sliding Fee:_____
(please request application)

Medicare _____ Private Pay:_____

Please present Insurance, Medicare and Medicaid cards to the receptionist when returning this form.

If Insurance is provided by party other than responsible party please list the Insured's date of birth:_____

Emergency Contacts

1.) Name:_____

Home Phone(_____)_____ Work Phone:(_____)_____

Relationship to patient:_____ Notes you wish to add: _____

2.) Name:_____

Home Phone(_____)_____ Work Phone:(_____)_____

Relationship to patient:_____ Notes you wish to add: _____

How did you hear about SEMO Health Network?

_____ School	_____ Friend	_____ Local Business
_____ Health Department	_____ Private Physician	_____ DAEOC
_____ Family Member	_____ Family Services	_____ Mission Missouri
_____ Chamber of Commerce	_____ Bootheel Healthy Start	_____ Media
_____ Hospital	_____ Home Health	_____Probation Officer

Other_____

Agreement

Please supply the Front Desk with a photo id.

Do you have an Advance Directive(Living Will)? _____Yes _____No

I agree that the above information is true and accurate.

_____ _____

Date Patient or Guardian Signature

SOUTHEAST MISSOURI HEALTH NETWORK
Sliding Fee Program Application

It is SEMO Health Network's policy to provide essential services regardless of the patient's ability to pay. Discounts are offered depending upon the family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

Head of Household_____Phone#:_____
Address: _____

List all family members of your household and their date of birth and income information below:
Proof of income for ALL family members of the household must be provided today.

Name:	**DOB:**	**Name:**	**DOB:**
_____		_____	
_____		_____	
_____		_____	

I, the undersigned patient or head of household, do hereby attest that the information provided for this application is complete and correct to the best of my knowledge. Any incomplete or incorrect information will be considered fraudulent and cause this agreement to be void. I understand that I will be required to provide proof of gross income **once every year** in order to verify continued eligibility for the Sliding Fee Program. Failure to provide said proof of income will cause this Discount to be discontinued until proof of income is provided and a new application processed. During this lapse of coverage, I will be responsible for 100% of all charges. I also understand that I am responsible to pay my portion of the charges at the time of service unless other arrangements are made PRIOR to the visit. I understand that failure to make payment or arrangements for payments in a timely manner may also cause this agreement to be void. If my income changes within the year, I must furnish new proof of income to SEMOHN.

I understand that the discount will apply to services received at the center but not services which are purchased from outside such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and similar services. I also understand that if I have insurance I must show a copy of my current insurance card at each visit and that insurance will be billed before receiving any Sliding Fee discounts. Workers Compensation and Motor Vehicle Accidents will not be given a discount.
Some procedures may be exempt from the Sliding Fee discounts. These charges should be discussed with you prior to services rendered.

_____ _____
Patient/Head of Household Signature Date Staff Witness Date

This section is for office use only.

SOURCE OF INCOME VERIFICATION

Tax Return	_____		
W2 from Prior Year	_____	Unemployment Check	_____
Payroll Stub	_____	Statement from Employer	_____
Worker's Comp Check	_____	Statement from SEMHN staff	_____
Letter from DFS	_____	Statement from SSI	_____

Total yearly gross income of <u>ALL</u> family members living in home:$_____

Patient/family will be responsible for a$ _____ fee for **MEDICAL** charges.

Patient/family will be responsible for _____% per procedure for **DENTAL** charges

Verified ___/___/___ by _____ Expires ___/___/___ Initials_____

rev 10/12 ct
updated 04/2014 tlf

Consent for Medical Treatment

1. **Authorization for Release of Information –** The HIPPA Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses and other medical information for treatment purposes with the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient.
2. **Consent for Healthcare Services –** I voluntarily consent to and authorize the rendering of health care services, including routine clinical services, diagnostic procedures, and other services or procedures which my provider considers necessary.
3. **Medicare Certification –** I certify that the information given by me in applying for payment under the Medicare program is correct. I request that payment of authorized benefits be made to SEMO Health Network on my behalf for the clinics for which SEMO Health Network is authorized to bill in connection with these health care services.
4. **Financial Agreement –** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of SEMOHN not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will be forwarded to the address on file with SEMOHN.
5. **Assignment of Direct Payment –** I authorize and direct that payment from any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to SEMOHN. I understand that I am financially responsible to SEMO Health Network for charges not covered or paid pursuant to this authorization.
6. **Personal Valuables –** I understand that SEMOHN does not assume responsibility for the loss, damage or disposal of my personal property or money including but not limited to jewelry, clothing, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item while I am a patient at SEMOHN.
7. **Privacy Act –** I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I agree to read it carefully. I am aware that the Notice may be changed at any given time. I also give my consent for SEMOHN to release my health information to state and federally funded agencies. I was given the opportunity to review the Notice and ask questions regarding my privacy rights**.**
   I understand that SEMOHN will not discuss my protected health information or charges/payments with me or any family member or friend unless, that person is able to provide SEMOHN with your four digit code. (see HIPAA Form)
8. **Outside Fees –** I understand that some services I have performed will be referred to outside entities to process, such as laboratory services and x-ray readings. I give permission to disclose my demographic and any health information to the entities for the processing of the services and/or billing my Insurance payor. I also understand that these entities will bill any Insurance sources that I have and I will be responsible for any non-covered charges. I acknowledge that I will receive statements from the mentioned entities.

I acknowledge that I have read this form and understand its contents. I further acknowledge that I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to and accept its terms.

_____ _____

Signature of patient or legal guardian Date Patient Name

_____ _____

Relationship to Patient Witness to Signature Date

Corporate Office
420 SEMO Dr
P.O. Box 400
New Madrid, MO
63869
Ph. - 573-748-2404
Fax - 573-748-8929

SEMO HEALTH NETWORK

HIPAA Privacy

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used or maintained by a covered entity. *Southeast Mo Health Network* is committed to protecting the privacy of our patient records.

Please assign a four digit code for security purposes and protection of your account with us. This number is required when calling any Semo Health Network office regarding questions pertaining to your account. This number should be kept in a safe place or memorized for your protection.

Below you may list up to 3 people who may contact us on your behalf. You will need to provide them with the number assigned in order for us to speak with them.

People who are able to contact Semo Health Network on my behalf:

1. _____
2. _____
3. _____

Pin#: _____

_____ (Print patient's name)

_____ (Signature of patient/legal guardian)

_____ (Relationship to patient)

_____ (Staff signature)

SOUTHEAST MISSOURI HEALTH NETWORK
AUTHORIZATION TO GATHER/RECEIVE
MEDICAL RECORDS OR HEALTH INFORMATION

The Execution of this form does not authorize the release of information other than that specifically described below. the information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that your specify. Your disclosure of the information requested on this form is voluntary. However, if the information, including the Social Security Number (which will be used to locate records for release) is not furnished completely and accurately, Southeast Missouri (Semo) Health Network will be unable to comply with the request. Semo Health Network may not condition treatment, payment, enrollment or eligibility on signing the authorization.

Patient's Full Name:_____

Patient's Social Security Number: _____ Patient Date of Birth:_____

Name and Address of Organization, Individual or Title of Individual from Whom Information Is to Be Gathered:

Site to Which Health Information Should Be Sent:

[ ] 421 SEMO Drive/P.O. Box 400, New Madrid, MO 63869
[ ] 200 Southland Drive, Sikeston, MO 63801
[ ] 314 E. Main Street, Portageville, MO 63873
[ ] Bootheel Dental Clinic, 202B Main Street/P.O. Box 400, New Madrid, MO 63869
[ ] Sikeston Dental Clinic, 220 Southland Drive, Sikeston, MO 63801
[ ] 500 Russell Street, Kennett MO 63857
[ ] 741 S. Walnut Street, Bernie, MO 63822
[ ] 6724 Highway 77 East, Benton, MO 63736
[ ] 102 N. Market Street, Senath, MO 63876

Patient's Request: I request and authorize Semo Health Network to gather the information specified below from the organization or individual named on this request. I understand that the information to be released includes information regarding the following conditions:

PLEASE MARK BELOW IF APPLICABLE

[ ] DRUG ABUSE [ ]ALCOHOLISM OR ALCOHOL ABUSE [ ] SICKLE CELL ANEMIA
[ ] TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each).

[ ] Copy of Hospital Summary_____ [ ]Copy of Outpatient Treatment Note(s)_____

[ ]Other (Specify)_____

[ ] Lab Reports_____ [ ]X-Ray Reports_____ [ ]X-ray Films

[ ]Handicap Parking Permit/Application [ ] Physician Work Statement/Disability Statement

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PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

[ ]Personal [ ]Payment [ ]Benefits [ ]State Reporting [ ]Other_____

[ ]Treatment [ ]Legal [ ]Congressional [ ]Research

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Medical Records Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ date supplied by patient); or (3) under the following condition(s):

Release will be valid for a period of one (1) year from date signed unless otherwise specified above or revoked.

_____ _____

Signature of Patient or Person Authorized to Sign for Patient Date