

Patient Name: _____

Date of Birth: ____/____/____

Today's Date: _____

CHILD HEALTH HISTORY FORM

Reason for your child's visit today: _____

Name of child's physician: _____ City: _____

Physician's phone number: _____

Please list any medications, over-the-counter drugs, or supplements the child takes:

Please circle if your child has had an allergic or adverse reaction to the following substances:

Amoxicillin/Penicillin Codeine Latex Local Anesthetic Iodine Metals Sulfa

Dental Materials Seasonal Aspirin Other: _____

General Health

	Yes	No	Unknown
Has your child ever had an operation? If yes, please explain: _____			
Has your child had an unfavorable experience in a medical or dental office?			
Does your child have any special limitations (mental, emotional, or physical)? If yes, please explain: _____			

Review of Systems:

Please mark all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> ADD or ADHD
<input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma or Breathing Problems
<input type="checkbox"/> Autism
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Chronic Infections
<input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eyesight Problems
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hemophilia | <input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Learning Disabilities
<input type="checkbox"/> Liver Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Seizures
<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Speech Impairments
<input type="checkbox"/> Total Joint Replacement |
|--|---|--|

Please list any other conditions, illnesses or special needs your child may have not listed above:

Dental History

	Yes	No	Unknown
Has your child ever had any injuries to the teeth, mouth, head or neck?			
Does your child have a history of thumb/finger sucking, pacifier use or nail biting?			
Has your child had a toothache lately? If yes, did the child awake from sleep? _____ Does it hurt after eating? _____			
Does your child eat or drink sugary drinks or foods throughout the day?			
Does your child play any contact sports? (Examples: football, soccer, wrestling)			
Does your child use any tobacco products?			
Do you have a family history of dental or gum disease?			

 When does your child brush his or her teeth? After waking up After meals Before bed Never

 When does your child floss his or her teeth? Daily Weekly Rarely Never

 How do you think your child will react to this dental visit? Very poor Poor Well Very well

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

 X _____ /_____/_____
 Signature of Parent or Guardian 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
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Language best served in:	___English ___Chinese ___French	___German ___Italian ___Spanish	___Japanese ___Sign Language ___Other _____
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Housing Status:	___Not Homeless ___Homeless Shelter ___Other _____	___Doubling Up ___Street	___Transitional ___Unknown
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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



Parent Permission Form

In the event you are unable to bring your child/children for an appointment, SEMO Health Network requires your permission for another adult to bring your child in to our clinics for Medical/Dental treatment.

Please list any adult that has permission to bring your child in:

Patient's Name: _____ **DOB:** _____

Parent Name: _____

Legal Guardian (if different from parents) _____

1. _____ **Relationship to patient** _____
2. _____ **Relationship to patient** _____
3. _____ **Relationship to patient** _____
4. _____ **Relationship to patient** _____
5. _____ **Relationship to patient** _____

Parent Signature

Date

SEMOHN Staff

Date

Witness

Date

Please keep in mind that only the persons listed above will be allowed to sign for your child.



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



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 you 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:

- | | |
|--|---|
| <input type="checkbox"/> 421 SEMO Drive/P.O. Box 400, New Madrid, MO 63869 | <input type="checkbox"/> 500 Russell Street, Kennett MO 63857 |
| <input type="checkbox"/> 200 Southland Drive, Sikeston, MO 63801 | <input type="checkbox"/> 741 S. Walnut Street, Bernie, MO 63822 |
| <input type="checkbox"/> 314 E. Main Street, Portageville, MO 63873 | <input type="checkbox"/> 6724 Highway 77 East, Benton, MO 63736 |
| <input type="checkbox"/> Bootheel Dental Clinic, 202B Main Street/P.O. Box 400, New Madrid, MO 63869 | |
| <input type="checkbox"/> Sikeston Dental Clinic, 220 Southland Drive, Sikeston, MO 63801 | <input type="checkbox"/> 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

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