Southeast Missouri Health Network
Patient Registration

Chart #_____

Patient Information

Last Name:_____ First Name:_____MI:_____

DOB:_____ SSN:_____ Gender: M F

Street Address:_____ PO BOX:_____

City:_____ State:_____ Zip:_____

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

Marital Status: ___Single ___Married ___Divorced ____Separated

Email address:_____ Pharmacy:_____

Employment Status: ____Full Time ____Part-Time ____None ____Student

Employer:_____ Address:_____

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

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

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

Name:_____

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

Street Address:_____

Notes regarding Contact:_____

_____

_____

How did you hear about Us

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	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

SEMO HEALTH NETWORK

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 understand that I should 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 any family member or friend unless that person is able to provide SEMOHN with the following four digit code number:_____.
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 | Patient Name

_____ _____

Relationship to Patient | Witness to Signature

_____

Date

Past Medical History Pediatric

Last Name:_____ First Name:_____

DOB:_____

Hospitalizations

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Prior Surgery

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Date:_____ Reason:_____

Social History

Living Environment

Parent _____
Step Family _____
Relatives other than parent _____
Significant other _____
Roommate _____
Foster Home _____
Group Home _____
Homeless Shelter _____
Poverty Conditions _____
Awaiting DSS Investigation _____
Legal Guardian _____

Sisters _____ # Brothers _____

Exposed to cigarette smoke at home ____Y ____N
# of family members in home _____
Has Heat Source ____Y ____N
Has City Water ____Y ____N
Has Well Water ____Y ____N
Guns in home ____Y ____N
Pets or other animals ____Y ____N

Education & Other

Day Care _____

Currently in school _____
Public _____
Private _____
Home _____

Grade _____

Having difficulty _____
Excelling _____

Active in Sports ____Y ____N
Type of Sports _____
_____

Tobacco Use ____Y ____N
Alcohol Use ____Y ____N
Drug Use ____Y ____N Type_____

Sexually Active ____Y ____N
Condom Use ____Y ____N
Homosexual Activity ____Y ____N

Other Activities:

Bicycling _____
Fishing _____
Hiking _____
Hunting _____
Motorcycling _____
Running _____
Skateboarding _____
Skiing _____
Surfing _____
Walking _____
Water Skiing _____
Other: _____

Comments:_____
_____
_____

Past Medical History

Abuse/Neglect	_____	Febrile Convulsions	_____
Allergic Rhinitis	_____	Fracture	_____
Anemia	_____	GERD	_____
Asthma:	_____	Headache	_____
Mild Intermittent	_____	Hearing Loss	_____
Mild Persistent	_____	Immunologic Disorder	_____
Moderate Persistent	_____	Jaundice	_____
Severe Persistent	_____	Measles	_____
ADD/ADHD	_____	Mental Illness	_____
Blood Disorders	_____	Migraine	_____
Cancer	_____	Mononucleosis	_____
Cerebral Palsy	_____	Mumps	_____
Chickenpox	_____	Otitis Media-Frequent	_____
Concussion	_____	Pneumonia	_____
Congenital Heart Disease	_____	Preterm Infant	_____
Congenital Malformations	_____	Scarlet Fever	_____
Constipation	_____	Seizure Disorder	_____
Development Disorder:	_____	Sinusitis-Multiple	_____
Mental Retardation	_____	Special Education	_____
PDD/ASD (Autism)	_____	Speech Difficulties	_____
Specific Disorder	_____	Tonsillitis	_____
Diabetes Mellitus	_____	Tuberculosis	_____
Drug Related Disorder	_____	URI	_____
Eczematoid Disorder	_____	Urinary Tract Infection	_____
Enuresis	_____	Vesicoureteral Reflux	_____
Eyesight Problems	_____	Other_____	

Please bring ALL of your medications to your visit.

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

SEMO HEALTH NETWORK

Patient Health Record Information Sheet

Providing the best care possible is very important to us. We want to ensure you have received testing and/or immunizations at age appropriate levels. Please complete the following so that we may obtain the corresponding records.

Patient Name: _____ DOB: _____

Date of last PAP: _____

Provider/Facility: _____

Address: _____

Phone #: _____

Have you had a hysterectomy? ____ yes ____no

If so, when? _____

Date of last Mammogram: _____

Provider/Facility: _____

Address: _____

Phone #:_____

For Children

Where did your child receive his/her immunizations ? _____

Shot record was brought in today: ____yes ____ no

For Nursing only if shot record was reviewed

Is this child up to date on his/her shots? ____ yes ____ no

SEMO HEALTH NETWORK

Parent Permission Form

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.

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

Patient's Name: _____ DOB: _____

Mother's name: _____ Father's name: _____

Legal Guardian (if different from parents) _____

1. _____
2. _____
3. _____
4. _____
5. _____

_____

Parent Signature **Date**

_____

Witness **Date**

_____

Witness **Date**

rev 5/12 jt
QA Approved 5/23/12