

**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 Hawaiian _____ 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



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

**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 Line Street/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

- | | | |
|---|--|---|
| <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> ALCOHOLISM OR ALCOHOL ABUSE | <input type="checkbox"/> SICKLE CELL ANEMIA |
| <input type="checkbox"/> 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).

- | | | |
|---|---|--|
| <input type="checkbox"/> Copy of Hospital Summary _____ | <input type="checkbox"/> Copy of Outpatient Treatment Note(s) _____ | |
| <input type="checkbox"/> Other (Specify) _____ | | |
| <input type="checkbox"/> Lab Reports _____ | <input type="checkbox"/> X-Ray Reports _____ | <input type="checkbox"/> X-ray Films _____ |
| <input type="checkbox"/> Handicap Parking Permit/Application <input type="checkbox"/> 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

- | | | | | |
|------------------------------------|----------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/> Personal | <input type="checkbox"/> Payment | <input type="checkbox"/> Benefits | <input type="checkbox"/> State Reporting | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Legal | <input type="checkbox"/> Congressional | <input type="checkbox"/> 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

Past Medical History Adult

Last Name: _____ First Name: _____

DOB: _____

Hospitalizations

Please list any hospitalizations that have occurred in the past 2 years:

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Past Medical History

Arthritis	___	Y	___	N	Heart Disease	___	Y	___	N
Arthritis, Rheumatoid	___	Y	___	N	Hepatitis	___	Y	___	N
Asthma	___	Y	___	N	HIV Infection	___	Y	___	N
Backache	___	Y	___	N	Hypertension	___	Y	___	N
Bleeding (Hematology) Disease	___	Y	___	N	Liver, Stomach, Bowel Disease	___	Y	___	N
Cancer	___	Y	___	N	Nonmoving Limbs	___	Y	___	N
COPD	___	Y	___	N	Numbness	___	Y	___	N
Depression	___	Y	___	N	Osteoporosis	___	Y	___	N
Diabetes	___	Y	___	N	Renal Disease	___	Y	___	N
Dizziness	___	Y	___	N	Respiratory Disorder	___	Y	___	N
Eyesight Problems	___	Y	___	N	Seizure Disorder	___	Y	___	N
Fainting	___	Y	___	N	Spine Disorder	___	Y	___	N
Gallbladder Disease	___	Y	___	N	Stroke Syndrome	___	Y	___	N
Gastric Ulcer	___	Y	___	N	Thyroid Disease	___	Y	___	N
Gout	___	Y	___	N	Urinary Tract Infection	___	Y	___	N
Headache Syndromes	___	Y	___	N	Venereal Disease (STD)	___	Y	___	N
Hearing Loss	___	Y	___	N	Other	___	Y	___	N

Prior Surgery

Year: _____ Reason: _____

Year: _____ Reason: _____

Year: _____ Reason: _____

Year: _____ Reason: _____

Year: _____ Reason: _____

Physical Trauma

Have you had any type of trauma: Y N If yes, complete type below:

Sports Injury: _____

Motor Vehicle Accident: _____

Other: _____

Body area affected by trauma: _____

Animal Bite/Scratch: _____ Location: _____

Social History

Education & Work History:

of Education years: _____ Level of school attended: _____

Working Full time: Y N

Working Part time: Y N # of hours per week _____

Currently of disability Y N Other work history: _____

Type of Occupation: _____

Living Situation:

Living independently with spouse Y N

Living independently alone Y N

Living with parents Y N

Other Living situations Y N Explain: _____

Nursing Home Y N

Is your home secure and supportive Y N If no; please explain: _____

Racial & Cultural:

Native Language: _____

Racial Background: _____

Cultural Background: _____

Marital/Social:

Currently Married Y N Widowed Y N

Previously Married Y N Sexually Active Y N

Never Married Y N Religious Affiliation Y N

Single Y N Military History Y N

Separated Y N Financial Status _____

Divorced Y N Number of children _____

Caffeine use: # cups of coffee per day _____ Other caffeine per day _____

Do you drink alcohol ___Y___N Have you ever drank alcohol ___Y___N

Do you drink alcohol socially ___Y___N Heavy alcohol consumption ___Y___N

Do you smoke cigarettes ___Y___N # packs per day _____ # of years _____

Do you chew tobacco ___Y___N # of years _____

Do you use drugs ___Y___N If yes type: _____

Please bring ALL of your medications to your visit.

Family History

Please check all that apply:

Disease/Condition	Mom	Dad	Mom's Mom	Mom's Father	Dad's Mom	Dad's Father	Brother	Sister	Son	Daughter	Other
Diabetes Mellitus											
Tuberculosis											
Heart Disease											
Hypertension											
Stroke Syndrome											
Cancer											
Seizure Disorder											
Mental Illness											
Bleeding Problems											
Anemia											
Autoimmune Disease											
Thyroid Disorders											
TIA											
Migraine Headache											
Neurology											
Backache											
Genetic Disease											
Birth Defects											
Kidney Disease											
Alcoholism											
Chronic Disabling Disease											
Other:											

Mother's age: _____ Father's age: _____ Other family history comments: _____
 Mother deceased at age: _____ Father deceased at age: _____



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