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:		Ethnic Background:
____White	____American Indian	_____Hispanic or Latino
____Black	____Pacific Islander	_____Non-Hispanic or Latino
____Asian	____Native Hawaiin	_____Unknown
____Other	____More than 1 race	

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

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
__________ Health Department
__________ Family Member
__________ Chamber of Commerce
__________ Hospital
__________ Friend
__________ Private Physician
__________ Family Services
__________ Bootheel Healthy Start
__________ Home Health
__________ Local Business
__________ DAEOC
__________ Mission Missouri
__________ Media
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 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
[ ] 200 Southland Drive, Sikeston, MO 63801
[ ] 314 E. Main Street, Portageville, MO 63873
[ ] 500 Russell Street, Kennett MO 63857
[ ] 741 S. Walnut Street, Bernie, MO 63822
[ ] 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

Release of Info (HIPAA)rev12/05cm/rev04/12cm

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

Condition			Condition	
Arthritis	___Y___N		Heart Disease	___Y___N
Arthritis, Rheumatiod	___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	Type:____________	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
Gallblader 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
Previously Married ____Y____N
Never Married ____Y____N
Single ____Y ____N
Separated ____Y ____N
Divorced ____Y ____N

Widowed ____Y ____N
Sexually Active ____Y ____N
Religious Affiliation ____Y ____N
Miltary History ____Y ____N
Financial Status ______________
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: _______
Mother deceased at age:________

Father's age:________
Father deceased at age:__________

Other family history comments:________________________________
____
____

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 ________ # Sisters _________ # Brothers _________
Significant other ________
Roommate ________
Foster Home ________
Group Home ________
Homeless Shelter ________
Poverty Conditions ________
Awaiting DSS Investigation ________
Legal Guardian ________

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 ________

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

Active in Sports ____Y ____N
Type of Sports ____

____

Other Activities:

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

Comments:____

____

____

Past Medical History

Abuse/Neglect ________
Allergic Rhinitis ________
Anemia ________
Asthma: ________
  Mild Intermittent ________
  Mild Persistent ________
  Moderate Persistent ________
  Severe Persistent ________
ADD/ADHD ________
Blood Disorders ________
Cancer ________
Cerebral Palsy ________
Chickenpox ________
Concussion ________
Congenital Heart Disease ________
Congenital Malformations ________
Constipation ________
Development Disorder: ________
  Mental Retardation ________
  PDD/ASD (Autism) ________
  Specific Disorder ________
Diabetes Mellitus ________
Drug Related Disorder ________
Eczematoid Disorder ________
Enuresis ________
Eyesight Problems ________

Febrile Convulsions ________
Fracture ________
GERD ________
Headache ________
Hearing Loss ________
Immunologic Disorder ________
Jaundice ________
Measles ________
Mental Illness ________
Migraine ________
Mononucleosis ________
Mumps ________
Otitis Media-Frequent ________
Pneumonia ________
Preterm Infant ________
Scarlet Fever ________
Seizure Disorder ________
Sinusitis-Multiple ________
Special Education ________
Speech Difficulties ________
Tonsillitis ________
Tuberculosis ________
URI ________
Urinary Tract Infection ________
Vesicoureteral Reflux ________
Other ____

____

Please bring ALL of your medications to your visit.