Greene County Health

PATIENT REGISTRATION FORM

Verified By:

DATE REC/ENTERED: ____/____/____

STAFF INITIALS: ________________

PATIENT INFORMATION *PLEASE COMPLETE (Fill out) entire form in* ***Black or Blue Pen Only***

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE

EMAIL ADDRESS

PREFERRED CONTACT METHOD
☐ PHONE ☐ EMAIL ☐ TEXT MESSAGE

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Civil Union

RACE
☐ African-American ☐ Native American
☐ Asian-American ☐ Pacific Islander
☐ Caucasian/White ☐ Multi-racial

Primary Language if Not English: ___________________________________

Do You Need Interpreter Services? ☐ YES ☐ NO

Ethnicity/Ethnic Origin: ☐ Hispanic ☐ Non-Hispanic

Primary Care Physician

AGRICULTURAL WORKER
☐ Migrant ☐ Seasonal

Are You a U.S. Veteran?
☐ Yes ☐ No

FAMILY FINANCIAL INFORMATION

Family/Household Size: ______________

Household Income: $ ______________

☐ Weekly
☐ Biweekly
☐ Monthly
☐ Annually
☐ Choose not to disclose

GENDER
☐ MALE
☐ FEMALE
☐ TRANSGENDER MALE
☐ TRANSGENDER FEMALE
☐ OTHER
☐ DO NOT WISH TO REPORT

SEXUAL ORIENTATION
☐ LESBIAN OR GAY
☐ STRAIGHT/HETEROSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ DON'T KNOW
☐ DO NOT WISH TO REPORT

GENDER AT BIRTH
☐ MALE
☐ FEMALE

As a Health Center we are required to collect this information. All answers are confidential.

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO

If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME | FIRST NAME | MI

STREET ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | HOME PHONE

Primary Insurance

☐ **I currently have MEDICAL insurance (see below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Medical Insurance Name: ___________________________________

Policy/ID Number: ____

Insured/Policy Holder's Information

Name: ____________________________________

Relationship to Patient:______________________

Date of Birth __________ Social Security # __________________

Seconday Insurance

☐ **I currently have Secondary MEDICAL insurance (see below)**
☐ **I currently DO NOT have Seconday MEDICAL insurance**

Medical Insurance Name: ___________________________________

Policy/ID Number: ____

Insured/Policy Holder's Information

Name: ____________________________________

Relationship to Patient:______________________

Date of Birth __________ Social Security # ______________

Greene County Health

Adult Health History

Name ____ Date of Birth______________________
(month/day/year)

I. ANSWER THE FOLLOWING QUESTIONS (Check Yes or No and fill in the blanks):			
#	Yes	No	**Questions**
1			Did you have a primary care physician? Who? _________________________Date of last exam: ______________
2			Do you have a dentist? Who? ______________________________ Date of last exam: _____________________
3			Have you been hospitalized or had a serious illness/injury in the last three years? Why? _____________________
4			Do you have chronic pain? When? ___________________ Where? _____________________________________ How often or frequent? ____
5			List current prescriptions (include vitamins, herbs, & supplements): ______________________________ ____

II. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Check Yes or No):							
#	Yes	No	Questions	#	Yes	No	Questions
6			Allergies to medications ________________________________	16			Allergies to food or other ________________________________
7			Hepatitis	17			High blood pressure
8			Anemia	18			Kidney or bladder disease
9			Arthritis	19			Psychiatric Illness ________________________
10			Asthma or Emphysema	20			Sexual disease: Chlamydia, Herpes, etc. ______
11			Cancer, Where? ___________________	21			Skin disease or rashes
12			Diabetes or Gestational (pregnant) Diabetes	22			Stomach problems: gastritis, ulcer, other _______
13			Eye disease: glaucoma, cataract, ______	23			Stroke
14			Ear, nose or throat problems	24			Thyroid, adrenal disease
15			Heart Disease				

III. HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS?							
#	Month	Year	Surgeries	#	Month	Year	Hospitalizations
25				29			
26				30			
27				31			
28							

IV. WOMEN ONLY (Check Yes or No):

#	Yes	No	Questions	#	Yes	No	Questions
32			Are you pregnant or breast feeding?	38			When was your last pap? ___________________
33			Are you taking birth control pills or shots?	39			Have you had an abnormal pap?
34			Do you have difficult periods?	40			When was your last mammogram? ___________
35			Have you had any miscarriages or abortions?	41			Have you had an abnormal mammogram?
36			More than 1 sexual partner recently?	42			Have you had a hysterectomy? Full or partial?
37			Do you have pain with intercourse?	43	At what age did you start your first period? _________________		

V. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Check Yes or No):

#	Yes	No	Questions	#	Yes	No	Questions
44			Swollen ankles	55			Dry mouth
45			Bleeding problems / bruising easily	56			Nausea and vomiting
46			Chest pain (angina)	57			Rashes
47			Cough: persistent or bloody	58			Seizures
48			Diarrhea, constipation, blood in stools	59			Shortness of breath
49			Dizziness	60			Sinus problems
50			Fever	61			Difficulty swallowing
51			Fainting	62			Excessive thirst
52			Headache	63			Frequent or bloody urine
53			Jaundice	64			Blurred vision
54			Joint pain or stiffness	65			Recent weight gain or loss

VI. OTHER INFORMATION (Check Yes or No and fill in the blanks):

#	Yes	No	Questions
66			Do you have any other diseases or medical conditions NOT listed on this form? If so, please explain: ________________________________
67			Please list any significant family medical history: ________________________________
68			Are you able to perform activities of daily living (ADL)? If no, please explain: ________________________________
69			Do you have a religious, cultural, physical, or other factors that might influence your care? If so, please list: ________________________________

VII. DO YOU USE ANY OF THE FOLLOWING? (Check Yes or No and fill in the blanks):

#	Yes	No	Questions	#	Yes	No	Questions
70			Alcohol frequency ___________________	72			Tobacco (smoke or chew) ___________________
71			Caffeine frequency _________________	73			Recreational drug frequency ________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my provider of any change in my health or medications.

Patient or Guardian's Signature (If under 18) ____ **Date** ___________________

For office use only: Baseline evaluation (all new illnesses are documented on the ongoing problem list).

PERMISSION TO RELEASE PROTECTED HEALTH INFORMATION

PRINT PATIENT'S FULL NAME:____

PATIENT'S DATE OF BIRTH:________________ **TELEPHONE:**________________________

PATIENT'S ADDRESS: ____

____

I give Greene County Health permission to discuss protected health information and to release test results to the following person(s):

NAME:___________________________________ **RELATIONSHIP:**_________________

NAME:___________________________________ **RELATIONSHIP:**_________________

NAME:___________________________________ **RELATIONSHIP:**_________________

I give Greene County Health permission to leave any protected health information on an answering machine or voicemail. ____Yes ___ No Telephone Number:______________

By signing this form, I give Greene County Health permission to send your medical information to the address provided.

Indicate your relationship to the patient: _____Patient _______Patient Representative

____

Print Name (if you are not the patient)

____ ______________________

SIGNATURE OF PATIENT OR AUTHORIZED REPRSENTATIVE **TODAY'S DATE**

This form is good for 1 year unless you tell us otherwise. If you want to, choose another date:

____

ADULT CONSENT & ACKNOWLEDGMENT FOR SERVICES

Name: ________________________________

Completion of this consent is necessary to offer services to a patient. Some items may not apply to your current situation; however, in order to provide comprehensive care during this visit and future visits we request that you complete this consent in its entirety. You have the privilege of revoking this consent, by providing written notice, at any time.

CONSENT FOR TESTING AND TREATMENT

By initialing below, I authorize the health care providers at Greene County Health (GCH), to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. I understand I may ask my health care providers about my care, treatment and procedures at any time and I am encouraged to do so.

_____ (Initials)

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

By initialing below, I understand and acknowledge that Greene County Health is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice such as improving care and treatment services.

_____(Initials)

ASSIGNMENT OF BENEFITS

By initialing below, I hereby assign to Greene County Health any and all payments to which I am entitled under Medicaid, Medicare and/or third party insurer for health care or behavioral services rendered to me by Greene County Health. I further authorize Greene County Health to bill and receive payment directly from Medicaid, Medicare or my insurance carrier(s) for those services that Greene County Health delivered and for which I may be entitled to insurance coverage. I also authorize Greene County Health to give Medicaid, Medicare and/or my health insurance carrier(s) any information necessary for billing purposes for services provided for such periods of time as I have received or am receiving primary health care or behavioral health services

_____ (Initials)

FINANCIAL RESPONSIBILITY

By initialing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from Greene County Health. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments.

_____ (Initials)

TERMS OF CONSENT

By signing below, I agree to the terms and information above. I am giving this consent of my own free will.

I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

______________________________ ______________

Patient Name Printed Initials

______________________________ ______________

Signature of Patient or Parent / Guardian or Power of Attorney Date

______________________________ ______________

Witness Signature Date

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient Name: ______________________________________ Date of Birth: _____/_____/______ Phone: _________________________

Address: ____ City: _________________________ State: ______ Zip Code: ___________

Healthcare Provider to ***Release*** Information:

Name	
Mailing Address	
Phone	**Fax**

Person/Agency to ***Receive*** Information: ☐ **Patient/Self**

Name Greene County Health 1600 A St. NE, Linton, In 47441 PH: 812-847-7005 FAX: 812-847-5309

PURPOSE OF THE DISCLOSURE _____ Transfer of Care _____ Coordination of Care _____ Other ______________________________

DATES REQUESTED _____ **ALL** Dates of Service **OR** Date Range: From ______________________ To _______________________

INFORMATION REQUESTED (**Must initial each item requested**):

_____ Initial here to include **ALL** types of records indicated below **OR** initial the specific records requested

_____ Chart Notes
_____ Lab Results
_____ Radiology and Imaging Reports
_____ EKG Reports
_____ Specialist Consults
_____ Hospital Records
_____ Physical Therapy Notes
_____ Other ____
_____ Immunization Records
_____ Billing Statements

SPECIFIC CONSENT (**By initialing the space(s) below, I am specifically authorizing the release of the specified confidential information**):

_____ Records regarding mental illness or developmental disability*
_____ Medical Records relating to alcohol and/or drug abuse
_____ HIV Test Results
_____ Genetic Testing information and results
_____ Communicable Disease
_____ Venereal Disease
_____ Child Abuse and Neglect
_____ Sexual Assault

EFFECTIVE DATE OF AUTHORIZATION

_____ Until the purpose is fulfilled
_____ Other ____

I understand that I may revoke this Authorization in writing at any time by notifying the Medical Records Department. I understand that once my health information is disclosed to the recipient, GCH cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read and understood this authorization and had a chance to ask questions about the disclosure of the health information. I authorize GCH to release my health information in the manner described above.

____

Signature of Patient or Personal Authorized by Law **Date**

____

***Name and Signature of Witness** *(required for release of information about mental illness or Developmental disability)* **Date**

Staff Initials_________

GREENE COUNTY HEALTH SLIDING FEE APPLICATION

Patient Information			**Today's Date: / /**		
First Name:	Middle:	Last:	Other names:		
Home Address:		City:	State:	Zip:	
Mailing Address:		City:	State:	Zip:	
Home Phone #: ( ) -		Home Phone #: ( ) -			
Date of Birth: / /	Social Security # - -		Do you have insurance? (circle one) Yes No		
Marital Status:	Single	In a relationship	Married	Divorced	Separated Widowed

Household Size		
Name	**Date of Birth**	**Social Security Number** (LAST 4 ONLY)
	/ /	XXX -XX -
	/ /	XXX -XX -
	/ /	XXX -XX-
	/ /	XXX -XX-
	/ /	XXX -XX-

NOTE: To comply with federal regulations, in order to give you a discount on our medical services, it is necessary for us to ask some personal questions. Your answers will be kept on file and in strict confidence.
Income verification can be determined based on your previous year's income tax return or the most two recent paycheck stub. Your annual income and your family size will be used to calculate your discount.

Household Income			
Name	**Amount**	**Frequency (Circle one)**	**Employer:**
You	$	Weekly Monthly Yearly	
Spouse	$	Weekly Monthly Yearly	
Children	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
	$	Weekly Monthly Yearly	
TOTAL	$	Weekly Monthly Yearly	

Other Income	**You**	**Spouse**	**Children**	**Other**	**Subtotal**
Social Security					
Public Assistance					
Retirement Pension					
Unemployment Comp					
Child Support, Alimony					
Interest Income					
Other					
				TOTAL	$

DETERMINED BY FEDERAL POVERTY GUIDELINES:

- A- $20 Payment
- B- $25 payment
- C- $30 payment
- D- $35 payment
- E- $40 payment
- F- No discount

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Greene County Health if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Greene County Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

Date:_________________________ Name (Print):____

Do you (responsible party) believe $20 is a reasonable charge for our services? Yes ☐ No ☐

Self-Declaration

Must be completed if no proof of income is attached

Employer's Name or Self-Employed: ____

Gross wages per pay period: ____________________________

How often are you paid? (Check One): [ ] Daily [ ] Weekly [ ] Monthly

AFFIDAVIT: By signing, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, the household members listed are all solely dependent on that income and the explanation provided to verify my income level is true.

APPLICANT SIGNATURE: ____