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

HOUSING STATUS Are You Homeless? ☐ YES ☐ NO
If homeless, are you: ☐ Doubling Up (living with others) ☐ Shelter ☐ Street ☐ Transitional ☐ Unknown

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

### 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

# PEDIATRIC HEALTH HISTORY

## (Ages 0-18 years)

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 | | | Where was your child born? _____ |
| 2 | | | Were there any problems during your pregnancy? If yes, explain: _____ |
| 3 | | | Was your delivery Vaginal or C-Section? Was there any problems? If yes, explain: _____ |
| 4 | | | Was your child born premature? If yes, were there any problems? _____ |
| 5 | | | What was your child's birth weight? _____ Birth length? _____ |
| 6 | | | Does your child have a primary care physician? Who? _____ Date of last exam: _____ |
| 7 | | | Does your child have a dentist? Who? _____ Date of last exam: _____ |
| 8 | | | Is your child currently taking any medications? List: _____ |
| 9 | | | Has your child ever been hospitalized? Why? _____ Where? _____ |
| 10 | | | Has your child had any serious injuries? When? _____ Where? _____ |
| 11 | | | Has your child had any surgeries? When? _____ Where? _____ |
| 12 | | | Does your child have any allergies to medications? _____ |
| 13 | | | Does your child have any allergies to food, Asthma, Hives, Eczema, or Hay Fever? Other _____ |

| II. HAS YOUR CHILD HAD OR CURRENTLY HAVE HAD ANY OF THE FOLLOWING? (Check Yes or No): | | | | | | | |
|---|---|---|---|---|---|---|---|
| # | Yes | No | Questions | # | Yes | No | Questions |
| 14 | | | Problems walking | 22 | | | Nursed as an infant? How long? _____ |
| 15 | | | Problems toilet training | 23 | | | Problems with diet |
| 16 | | | Problems with colic | 24 | | | Use/d any special diets |
| 17 | | | Problems in school | 25 | | | Attended a special school or classes |
| 18 | | | Problems with sleeping | 26 | | | Nightmares |
| 19 | | | Problems with bedwetting | 27 | | | Discipline or behavior problems |
| 20 | | | Problems with nail biting | 28 | | | Ever seen a Psychologist |
| 21 | | | Problems with weight/height | 29 | | | Speech Therapist or Speech teacher |

| III. FOR FEMALES ONLY (Check Yes or No): | | | | | | | |
|---|---|---|---|---|---|---|---|
| # | Yes | No | Questions | # | Yes | No | Questions |
| 30 | | | Does your child have difficult menstrual periods? | 32 | | | Is your child taking birth control? |
| 31 | At what age did your child start her first period? _____ | | | 33 | | | Has your child had a miscarriage or abortion? |

**IV. HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS? (Check Yes or No)**:

| # | Yes | No | Questions | # | Yes | No | Questions |
|---|---|---|---|---|---|---|---|
| 34 | | | Head | 40 | | | Kidney/bladder |
| 35 | | | Eyes | 41 | | | Lungs/asthma/bronchitis/pneumonia |
| 36 | | | Ears/nose/throat | 42 | | | Bones/muscles/joints |
| 37 | | | Heart/murmur/high blood pressure | 43 | | | Anemia |
| 38 | | | Stomach/constipation | 44 | | | Skin/rashes |
| 39 | | | Wear glasses or contacts? | 45 | | | Wear dental bridges/plates/braces? |

**V. HAS YOUR CHILD HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS? (Check Yes or No):**

| # | Yes | No | Questions | # | Yes | No | Questions |
|---|---|---|---|---|---|---|---|
| 46 | | | Hepatitis | 49 | | | Diabetes |
| 47 | | | Chickenpox | 50 | | | Had a Seizure |
| 48 | | | Dizzy or passed out during or after exercise? | 51 | | | Been unconscious/had a concussion |

**VI. FAMILY HISTORY (Check Yes or No and fill in the blanks):**

| # | Yes | No | Questions | # | Yes | No | Questions |
|---|---|---|---|---|---|---|---|
| 52 | | | Father health problems | 54 | | | Brothers/sisters How many: _____ |
| 53 | | | Mother health problems | 55 | | | Brothers/sisters health problems |

**VII. ANY FAMILY HISTORY OF? (Check Yes or No and fill in the blanks)**:

| # | Yes | No | Questions | # | Yes | No | Questions |
|---|---|---|---|---|---|---|---|
| 56 | | | Diabetes | 60 | | | Convulsions |
| 57 | | | Allergies | 61 | | | Heart Disease |
| 58 | | | TB | 62 | | | Cancer |
| 59 | | | A.I.D.S/HIV | 63 | | | Hepatitis |

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

| # | Yes | No | Questions |
|---|---|---|---|
| 64 | | | Are you or your children exposed to domestic abuse/violence? |
| 65 | | | Does your child have any other diseases or medical conditions NOT listed on this form? If so, please explain: _____ |
| 66 | | | What is your child's last primary care doctors address: _____ |
| 67 | | | Where did your child live before coming to this area? _____ When did you move here? _____ |
| 68 | | | Is your child able to perform activities of daily living (ADL)? If no, please explain: _____ |
| 69 | | | Any special comments about your child? _____ |
| 70 | | | Do you have any religious, cultural, physical, or other factors that might influence your care? If so, please list: _____ |

**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).

Greene County Health

**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:

_____

Greene County Health

# 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 |

Greene County Health

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

**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* | _____ | Communicable Disease |
| _____ | Medical Records relating to alcohol and/or drug abuse | _____ | Venereal Disease |
| _____ | HIV Test Results | _____ | Child Abuse and Neglect |
| _____ | Genetic Testing information and results | _____ | 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: _____

Greene County Health

# Parental Authorization to Treat Minor Child When Not Accompanied by Parent or Guardian

I recognize that Greene County Health requires permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian. When parents/legal guardians are not immediately available and advanced consent has not been provided, time must be taken to obtain permission and treatment may be delayed or even denied. However, please note that during an emergency, care would not be delayed.

I also acknowledge that a specific treatment such as administration of a medication or procedure during a visit will require my verbal consent.

Below, please note my parental authorization given so that my minor child may receive treatment at Greene County Health without his or her parent being present. This authorization will become part of the patient record.

| | | | |
|---|---|---|---|
| Patient's Name | | Date of Birth | |
| Address | | | |

**Part A**

_____ (Initial) This certifies that the person listed below has my permission to authorize necessary medical care and/or sports physicals for my child. This authorization is in effect until revoked by me in writing.

The following persons(s) have my permission to authorize medical care/sports physicals for my child and to sign any necessary general consents or acknowledgements on my behalf. The following person will present valid ID for identification purposes and sign forms signifying my parental responsibility for payment.

| | |
|---|---|
| Name | |
| Address | |
| Name | |
| Address | |

Signature of Patient or Personal Authorized by Law

Date

**For Center Staff Only:** Date Received: _____

Greene County Health

**The FollowMyHealth™ patient portal at Greene County Health, INC is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form to authorize Greene County Health, INC to email an invitation to create a portal account.**

| **Purpose for Access:** | **PERSONAL ACCOUNT ACCESS:** ***(photo ID required)*** |
|---|---|
| | ☐ **I am the parent of a Minor patient aged 18 or younger and request access to be an authorized user on the FollowMyHealth patient portal account at Greene County Health, INC.** |

**Patient Information** *(please print)*: **(minor aged 18 or younger)**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____
MM/DD/YYYY

***I hereby authorize Greene County Health, INC to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Greene County Health, INC health care information:***

**Authorized User Information** (*please print)*: **(Person receiving access to a Patient Portal account)**

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
*(PERSONAL EMAIL REQUIRED)*

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: _____ Date: _____

**For Portal Use Only**

Patient Portal Invite sent by: Date: