Community Health Center of the Black Hills, Inc — ADULT REGISTRATION

Account Number: _____

PATIENT/CLIENT INFORMATION

Name: _____ Social Security Number: _____
Last First Middle

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip code: _____ Email Address: _____

Phone: (___) _____ Female ____ Male____ Other names used (alias): _____

Do we need to contact you at a different mailing address, phone # or through alternate method for confidentiality? ____ Yes___ No

Mailing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Is the Client a Family Planning client? ___ Yes ___ No If yes, who may CHCBH release information to: _____

EMPLOYER

Name: _____ Phone: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Employed ___ Full Time ___ Part Time, ___ Retired, ___ Self Employed, ___ Military

Student ___ Full Time ___ Part Time, ___ Unemployed (with or without unemployment benefits),

___ Legal Disabled (with or without SSDI benefits)

INSURANCE INFORMATION (copy of card is required to file claims)

Name of Primary Insurance and address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

POLICY HOLDER (PH) INFORMATION: Must be Completed

Name of Policy Holder: _____ Relationship to Patient: _____

PH Address: _____ Phone: _____

(required for claims processing) PH SSN _____ Date of Birth _____ Male Female

Insurance ID: _____ Group #: _____ Effective Date: _____

Do you have additional Insurance? _____ Yes _____ No (If yes, copy of card is required to file claims)

EMERGENCY CONTACT (Please list additional contacts on separate page).
Authorization for access to: Please "X" all that apply

Name: _____ Relationship: _____ Phone #: _____

Emergency ___ Yes ___ No, Appointment info ___ Yes ___ No, Test Results ___ Yes ___ No,

Billing Info ___ Yes ___ No, Rx pick up ___ Yes ___ No

Name: _____ Relationship: _____ Phone #: _____

Emergency ___ Yes ___ No, Appointment info ___ Yes ___ No, Test Results ___ Yes ___ No,

Billing Info ___ Yes ___ No, Rx pick up ___ Yes ___ No

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Rights and Responsibilities

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. The Patient Rights and Responsibilities informs or your rights and responsibilities as a CHCBH patient.

I acknowledge that I have received the Notice of Privacy Practices and *Patient Rights and Responsibilities* forms from the Community Health Center of the Black Hills.

_____ _____

Signature *Date*

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient *Print Name*

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1) Please select one of the following from the race listing:

- ☐ Asian
- ☐ Black/African American
- ☐ American Indian/Alaska native
- ☐ White (not Hispanic or Latino)
- ☐ Hispanic or Latino (all races)
- ☐ Refused to Report

2) Please select one of the following from the ethnicity listing:

- ☐ Hispanic
- ☐ Not Hispanic

3) What is the primary language spoken in your household:

- ☐ Spanish
- ☐ English
- ☐ Other _____
- ☐ Refused to Report

4) Do you need an interpreter? Yes _____ No _____

5) Please select marital status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Legally Separated
- ☐ Partner
- ☐ Other
- ☐ Refused to Report

6) Please select from the following that best describes your living situation:

- ☐ Rent/Own
- ☐ Transitional Housing
- ☐ Doubling up
- ☐ Homeless Shelter
- ☐ Other
- ☐ Not Homeless
- ☐ Unknown
- ☐ Refused to Report

7) Are you unable to work because of a physical or mental disability? Yes_____ No _____

8) Are you a veteran the Uniformed Services of the United States? Yes _____ No _____

9) How many family members are there living in your household? _____

10) Please select one of the following that best represents your family's total annual income:

- ☐ $0 – $20,000.00
- ☐ $20,500.00 - $32,000.00
- ☐ $32,500.00 - $44,000.00
- ☐ $44,500.00 - $56,000.00
- ☐ $56,500.00 - $68,000.00
- ☐ $68,500 - $100,000.00
- ☐ Refused to Report

11) Sexual Orientation:

- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Don't know
- ☐ Lesbian, gay or homosexual
- ☐ Something else
- ☐ Choose not to disclose

12) Gender identity:

- ☐ Male
- ☐ Female
- ☐ Female-to-male (FTM)/Transgender Male/Trans Man
- ☐ Male-to-female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category/(or other), please specify_____

  _____
- ☐ Choose not to disclose

13) Sex you were assigned at birth on your original birth certifcate:

- ☐ Male
- ☐ Female
- ☐ Decline to answer

Entered by: _____

Account Number: _____

Chart Number: _____

Date: _____

Community Health Center of the Black Hills, Inc

CHCBH Discount Program Application

Name of Patient/Parent/Guardian		Phone	
Street	City	State	Zip
Social Security Number	Place of Employment		

Please list self, spouse, and dependents under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

OFFICE USE ONLY: Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

OFFICE USE ONLY: Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, two (2) most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection.		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Signature Date

Staff Initial: _____ Date: _____ Recertification Date: _____

Community Health Center of the Black Hills

PATIENT FINANCIAL POLICY

PAYMENT RESPONSIBILITY POLICY
(Financial Policy)

Payment is expected in full when services are rendered.
The following is our Patient Financial Policy.

Regarding Medicaid and/or Medicare

Please provide us with your current Medicaid and/or Medicare Card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service.

Private Insurance

Please provide us with a copy of your insurance card at each visit. If payment from the insurance company is not received by 120 days, I am responsible for the charges.
All co-pays and deductibles are due at time of service.

Private Pay Patients

Full payment is due at time of service. We accept CASH, CHECK, and VISA/MASTERCARD (credit or debit card). We offer a CHCBH Discount Program if you qualify. Please ask a receptionist for additional information.
All CHCBH Discount Program co-pays are expected at the time of service.

I realize that I am responsible for any and all differences in charges and payments. I understand that I may be eligible for the CHCBH Discount Program but unless I bring in proof of income (within 10 business days of application), I am responsible for the entire bill. I understand that it is my responsibility to inform the staff of the CHCBH of any changes in my income, family status, or insurance status. I understand that it is my responsibility to update financial paper work on a yearly basis. I further understand that providing CHCBH with false information will result in immediate recalculation of the sliding fee scale for those patient fees occurring during the fraudulent periods and all fees will be due and payable immediately.

Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below you acknowledge and accept our Patient Financial Policy.

X_____ ☐ _____
Print Name of Patient Initial's
Decline Discount

X_____ Date_____
Signature of Patient or Responsible Party

Patient/ Patient Family has qualified for the CHCBH Discount Program at level: _____

Patient's visit co-pay will be _____ at each visit.

Please note that this is a minimum payment and patient/patient family is responsible for any remaining balance after the discount has been applied to the services rendered.

You may receive a separate billing statement from an outside medical source for laboratory and/or X-ray services.

Staff initials _____ Date _____ Recertification Date _____

Community Health Center
OF THE BLACK HILLS

DENTAL PATIENT MEDICAL HISTORY

*Please complete the **Patient Identification** section in order to update our records.*

Name: _____ Date of Birth: _____ Home Phone: (_____) _____

Cell Phone: (___)_____ Mail Address : _____ City:_____ State:_____ Zip:_____

If you are unsure how to answer any of the following questions, please ask the dental staff for help.

What is the reason for your visit to the dental clinic? _____

What is the name of your medical doctor? _____ **Last Physical Exam**_____

Has there been any change in your general health this past year? Yes____ No _____

If you answered yes please explain _____

Do you require a **PREMED** or antibiotic before dental treatment (artificial joint or heart condition) Yes____ No____

If yes, why_____

List any medication (pills or drugs) you are currently taking: _____

Are you **ALLERGIC** to or made sick by any medications? _____

What is your sexual orientation? ____ Heterosexual ____ Homosexual ____ Something Else
____ Bisexual ____ Do not wish to say

What is your gender? _____ Male _____ Female _____Other _____ Refused to Report
_____ Transgender Male/Female-to-Male _____ Transgender Female/ Male-to-Female

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Yes____ No____ 1. Do you use alcohol or other drugs?

Yes____ No____ 2. Do you have a toothache now?

Yes____ No____ 3. Have you taken medication in the last two months?

Yes____ No____ 4. Do you take Bisphosphonates?

Yes____ No____ 5. Have you ever been hospitalized?

Yes____ No____ 6. Do you have chest pains?

Yes____ No____ 7. Have you received medical care in the past two years?

Yes____ No____ 8. Have you ever had a bleeding problem that needed medical treatment?

Yes____ No____ 9. Do you have AIDS or HIV?

Yes____ No____10. Do you have Diabetes?

Yes____ No____11. Does anyone in your family have Diabetes? Who? _____

Yes____ No____12. Are you currently receiving care for your Diabetes?

Yes____ No____13. Do you receive care for your Diabetes at CHCBH?

14. Tobacco Use (select all that apply):

____ Never smoked ____ Smoker
____ Occasional smoker ____ Ex-Smoker
____ Smokes daily ____ Other tobacco use

Do you have or have you ever had any of the following:

Yes____ No____ 15. TB or Lung Disease

Yes____ No____ 16. Hepatitis

Yes____ No____ 17. Heart Murmur

Yes____ No____ 18. Heart Attack

Yes____ No____ 19. High Blood Pressure

Yes____ No____ 20. Rheumatic Fever

Yes____ No____ 21. Kidney Problems

Yes____ No____ 22. Heart valve or Pacemaker?

Yes____ No____ 23. Artificial Joint

Yes____ No____ 24. Anemia

Yes____ No____ 25. Stroke

Yes____ No____ 26. Ulcers

Yes____ No____ 27. Asthma

Yes____ No____ 28. Sinus Trouble

Yes____ No____ 29. Cancer or Tumors

Yes____ No____ 30. Epilepsy or seizure

Yes____ No____ 31. Arthritis/Rheumatism

Yes____ No____ 32. Blood Transfusion

Yes____ No____ 33. Sexually transmitted diseases

Yes____ No____ 34. Liver Problems

Yes____ No____ 35. Mental Disorders

Yes____ No____ 36. Depression

Yes____ No____ 37. Osteoporosis

Yes____ No____ 38. Acid Reflux

Females Only:

Yes____ No____ 39. Are you pregnant?

Yes____ No____ 40. Taking birth control pills?

Yes____ No____ 41. Currently Nursing?

Do you have any conditions/problems, not listed above, which may be a factor in your treatment? Yes____ No____

Who is your present dentist?_____

Do you have concerns about receiving dental treatment? Yes___ No___ If yes specify_____

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleanings, fillings, crowns, and local anesthesia by signing below.

Patient or Legal Guardian Signature:_____Date:_____

Notes (For dental staff use):_____

Dentist Signature:_____ Date_____

Provider Review: Date_____ Ini. _____ Date_____ Ini. _____ Date_____ Ini. _____ Date_____ Ini._____