COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Date: _____

REGISTRATION FORM

1. Name (First and Last): _____ M.I. _____ Date of Birth: _____
2. Address: _____
   Apartment: _____ City/State: _____ Zip Code: _____
   ☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Work Phone: _____
3. E-mail address: _____ Social Security: _____ - _____ - _____
4. *Gender Identity: ☐ Female ☐ Male ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer ☐ Other ☐ Decline to answer
5. Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose
6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
7. Race (Check all that apply):
   ☐ Asian ☐ Black ☐ White
   ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

   Ethnicity (Check one): ☐ Hispanic/Latino ☐ NOT Hispanic/Latino
8. Language:
   ☐ Albanian ☐ English ☐ Hmong ☐ Laotian ☐ Sign Language
   ☐ Arabic ☐ French ☐ Japanese ☐ Portuguese ☐ Tagalog
   ☐ Cambodian (Khmer) ☐ German ☐ Korean ☐ Russian ☐ Vietnamese
   ☐ Chinese ☐ Greek ☐ Kreyól ☐ Spanish ☐ Other
9. Is the patient a US citizen? ☐ Yes ☐ No
10. Employment Status*: ☐ Employed ☐ Self-employed ☐ Disabled ☐ Retired ☐ Student (Part time / Full time)
11. Emergency Contact name: _____ Phone: _____
12. Relationship to emergency contact: _____ Mother's maiden (last) name: _____

Parent/Legal Guardian Information (*complete only if patient is a minor*)
Mother's Name (First & Last): _____
Father's Name (First & Last): _____
Guardian's Name (First & Last): _____
Relationship to patient: ☐ Parent ☐ Grandparent ☐ Foster Parent ☐ Other: _____
Social Security: _____ - _____ - _____ Identification: _____

13. Annual Gross Monthly Income (before taxes): _____ Number of people supported in household: _____
14. Do you have insurance? ☐ Yes ☐ No If yes, what type of insurance? _____

Name of Policy Holder _____ Date of Birth _____

15. Are you a military veteran? ☐ Yes ☐ No
16. Are you homeless**? ☐ Yes ☐ No If yes, choose one of the following: ☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other

*Employment Status:

- Employed – You earn a living either working part-time or full-time for another individual, company or organization.
- Self-employed – You earn a living working from your own business and not earn salary or commission from another individual.
- Disabled – You receive monthly payments from the government for a disability
- Retired – You have retired from working and receive a social security check monthly
- Full-time/Part-time Student – You are enrolled in an accredited school on either a part-time (less than 12 credit hours) or full-time (12 credit hours or more).

**Homeless Status:

- Shelter – You are living in an organized shelter for homeless persons.
- Transitional Housing – You are residing in a small unit that helps a person transition from homelessness to permanent housing.
- Double Up – You are living with other individuals in their home and/or apartment.
- Street – You are living outdoors, in a car, in an encampment (tent city), in a makeshift housing/shelter.
- Other – You are living in a single room occupancy hotel or motel or other day-to-day paid for housing.

_____
Patient/Parent/Legal Guardian Signature

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

PATIENT CONSENTS AND ACKNOWLEDGEMENTS

		INITIAL
I.	**Consent for Treatment** I hereby give consent and authorize treatment at Community Health Centers of Pinellas, Inc. for myself, the patient.	
II.	**Consent for Treatment of a Minor** I, as the parent or legal guardian of the patient, do hereby give my consent and authorize treatment. Furthermore, I grant permission for _____ to authorize Medical Treatment in my absence.	
III.	**Residents and Students** I understand that Community Health Centers of Pinellas, Inc. supports the education of medical professionals and maintains Residents and Students that may assist in relation to care.	
IV.	**Notice of Privacy Practices** I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy.	
V.	**Release of Information** • Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment. • If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, drug and alcohol treatment and discharge summary. • Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases such as HIV and AIDS. I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, and/or healthcare operations.	
VI.	**Disclosure to Friends and/or Family Members** I give permission for my Protected Health Information to be disclosed for purposes of coordinating health care needs, communicating results, findings and care decisions to the friends and/or family members listed below:	

Name	Relationship	Contact Number

**You have the right to revoke whom we talk with about your health care at anytime. Please complete a new consent.

		INITIAL
VII.	Consent for Use and Disclosure of Protected Health Information (PHI)	

	Yes	No
May we call your job and leave a message? If yes, at what number? _____		
May we call your home and leave a message? If yes, at what number? _____		
May we leave a message concerning medical information on your cell phone? If yes, at what number? _____		

VIII. Consent to E-mail or Text Message for Appointment Reminders and Other Healthcare Communications.

Patients in our practice may be contracted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at anytime I provide an email or text address at which I may be contracted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or mobile number from the practice.

I consent to receive TEXT messages for: appointment reminders, feedback, and general health reminders/information at this mobile number: _____.

I consent to receive EMAIL messages for: appointment reminders, feedback, and general health reminders/information at this email address: _____.

Community Health Centers of Pinellas, Inc. does not charge for this service, but standard text messaging and data rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

IX. Revocation (If you DO NOT want to receive text messages or email from us about future appointment reminders, feedback, and general health).

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via TEXT messaging.

_____ _____
Signature of Patient or Parent/Guardian Date

☐ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via EMAIL.

_____ _____
Signature of Patient or Parent/Guardian Date

X. Patient Bills of Rights

The Patient Bill of Rights is posted in the lobby. I acknowledge that I have received a copy of the Bill of Rights.

XI. Notice of Policy Regarding Advanced Directives (for patients over 18 years of age)

Advanced Directives are legal statements that indicate the type of medical treatment wanted or not wanted in the event an individual is unable to make decisions as well as who is authorized to make them. Advance directives are made and witnessed prior to serious injury.

In accordance with federal and state law, this serves as notification that we will set aside your advance directive in the event you experience a life threatening event while at one of the Community Health Centers of Pinellas locations and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification.

Please indicate below whether or not you have an advanced directive or if you would like to receive information on advance directives.

☐ I have an advanced directive.

☐ I do not have an advanced directive.

☐ I would like to receive information on advanced directives.

XII. Medical Home: I choose to participate in the patient-centered medical home.

_____ _____
Signature of Patient or Parent/Guardian Date

COMMUNITY HEALTH CENTERS OF PINELLAS, INC.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

MEDICAL HISTORY FORM FOR DENTAL PATIENTS

Please answer the following questions:

If you are completing this for another person, what is your name and relationship? _____

Date of last physical exam: _____ Referred by: _____

Name of Primary/Specialty Physician: _____ Phone: _____

Address of Physician: _____

Patient's Sex: ☐ Male ☐ Female Patient's Height: _____ Patient's Weight: _____

	Yes	No		Yes	No
Are you in good health?	☐	☐	Are you wearing contact lenses?	☐	☐
Have there been changes to your health in last year?	☐	☐	Are you wearing removable dental appliances?	☐	☐
Do you take steroids/corticosteroids?	☐	☐	Do you smoke/chew tobacco?	☐	☐
Are you taking blood thinners?	☐	☐	If yes, how many packs/cans per day? _____		
Have you ever had chemotherapy or radiation?	☐	☐	Do you have any metal implants in your body?	☐	☐
If yes, was it to your head/neck?	☐	☐	If yes, where? _____		
Have you **ever** taken any medications for osteoporosis either via IV or pill form?	☐	☐	Have you ever had a broken jaw?	☐	☐
			Have you ever had braces?	☐	☐
If yes, what medication and for how long? _____			Have you had any complications with dental treatment?	☐	☐
			If yes, what? _____		
For Children: Has the child ever been sedated (put to sleep) for dental treatment?	☐	☐			

Medical History: Do you have any of the following? ☐ No ☐ Yes, please check all that apply

☐ Damaged/Artificial Heart Valves	☐ AIDS/HIV	☐ Kidney Disease/Dialysis	☐ Low Blood Pressure/Fainting
☐ Cardiovascular Disease	☐ Thyroid Disease	☐ Tuberculosis	☐ STD's
☐ Diarrhea or recent weight loss	☐ Respiratory Problems	☐ Persistent Cough	☐ Epilepsy/Seizures
☐ Diabetes	☐ Arthritis	☐ Coughing up Blood	☐ Mental Health Problems
☐ Liver Disease/Hepatitis	☐ Ulcers/Acid Reflux	☐ Swollen glands in neck	☐ Anemia/Sickle Cell
☐ Osteoporosis/Osteopenia	☐ Cancer	☐ Abnormal Bleeding	☐ Autoimmune Disease
☐ Asthma/COPD	☐ Blood Clotting Disorder		

If you checked Cancer, what kind? _____ When? _____

Allergies: Do YOU have any allergies? ☐ No ☐ Yes, please indicate items your are allergic to

☐ Drug/Medication Allergies: _____

☐ Local anesthetics
☐ Penicillin or other antibiotics
☐ Sulfa drugs
☐ Barbiturates, sedatives, or sleeping pills

☐ Food/Environmental: _____

☐ Aspirin
☐ Iodine

Hospitalizations/Surgeries:

Have you ever had any serious illness, operations, or been hospitalized in the past 5 years? ☐ No ☐ Yes, please fill out below

□ Serious Illnesses/Operations: _____

□ Hospitalizations: _____

Current Medicines: Include any prescription or over-the-counter medications (vitamins, antihistamines, Tylenol, herbs, etc.)

Medicine/Vitamin/Supplement Name	Dose-How much you take	How often do you take it?	Reason

WOMEN ONLY:

	Yes	No		Yes	No
Are you pregnant?	☐	☐	Are you nursing?	☐	☐
Do you have any problems associated with your period?	☐	☐	Are you taking birth control pills?	☐	☐

*Taking antibiotics may cancel out the effects of birth control, and you may get pregnant.

PLEASE TURN PAGE OVER →

Chief Dental Complaint: _____

_____

_____

_____

☐ I certify that I have read and understand the above. I acknowledge that my questions, if any, about this medical history form, have been answered to my satisfaction and I will not hold my dentist, or any member of the staff, responsible for any errors or omissions that I have made in the completion of this form.

☐ I understand that in the event there is any change in my health status, I should notify CHCP at the earliest possible time.

☐ I hereby consent to the administration of local anesthesia as may be considered necessary by the dentist in charge of my care. I understand the risks of local anesthesia include: local discomfort, swelling, bruising, sores, allergic reactions, seizures, and temporary and/or permanent numbing. I have also read the attached sheet of the benefits, risks, and complications of local anesthesia.

_____ _____

Signature of Patient/Legal Guardian Date

For completion by the Dentist:

☐ Medical Consult Required: _____

☐ Pre-Medication Required: _____

_____ _____

Signature of Dentist Date