CoxHealth

Regional Services

Patient Registration Form

Patient Name: (First, MI, Last) ______________________ SSN#: ____________ Today's Date: ____________

Address: ______________________________ City/State/Zip: ______________________________

Date of Birth : ___/___/____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Please complete all fields and check the phone number you would prefer messages to be left regarding your health care.

☐ Home Phone: ____________ ☐ Cell Phone: ____________ ☐ Other *(specify)*: ____________

OTHER INFORMATION

Name of **Patient's** Employer: ______________________________ Work Phone: ____________

Patient's Employer Address: ______________________ City/State/Zip: ______________________

Spouse Name: ______________________________ **Spouse** Work/Cell Phone: ____________

Emergency Contact: ______________________ Relationship: ____________ Phone: ____________

INSURANCE INFORMATION

Is this visit related to an accident? ☐ Yes ☐ No If yes, please specify if AUTO or Other: ____________

Is this visit related to a work related accident? ☐ Yes ☐ No If yes, please provide Workman's Comp Ins.

♦ **PRIMARY INS:** ______________________ **POLICY HOLDER NAME:** ____________

Policy Holder's Employer: ______________________ Policy Holder SSN#: ____________

Group #: ____________ Policy/ID #: ____________ Policy Holder DOB: ____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ____________

♦ **SECONDARY INS:** ______________________ **POLICY HOLDER NAME:** ____________

Policy Holder's Employer: ______________________ Policy Holder SSN#: ____________

Group #: ____________ Policy/ID #: ____________ Policy Holder DOB: ____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other (explain) ____________

PARENT OR GUARDIAN INFORMATION

Complete for Patients who are Minors or Patients with Guardians ONLY

♦ **RELATIONSHIP:** ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) ______________________ SSN#: ____________ Date of Birth: ____________

Address: ______________________ City/State/Zip: ______________________ Home Phone: ____________

Employer: ______________________ Work Phone: ____________ Cell Phone: ____________

♦ **RELATIONSHIP:** ☐ **Father** ☐ **Mother** ☐ **Guardian**

Name: (First, MI, Last) ______________________ SSN#: ____________ Date of Birth: ____________

Address: ______________________ City/State/Zip: ______________________ Home Phone: ____________

Employer: ______________________ Work Phone: ____________ Cell Phone: ____________

NEW PATIENTS ONLY - How did you hear about us?

☐ Health Plan Directory (HP) ☐ Friend/Relative (FR) ☐ Phone Book (PB) ☐ Radio/TV (RT)

☐ Printed Ad/Newspaper (PA) ☐ Urgent Care (UC) ☐ Other (OT) ☐ CoxHealth Web Site (WS)

☐ Another physician (AP) ☐ Billboard/Sign (BS) ☐ Cox INFO Line (IL) ☐ Don't Know (DK)

OVER – Please Read and Sign

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Authorization, Financial Obligation and Consent Form

Patient Name: ______________________ *Please Print* **Patient DOB or SSN:** ______________

Authorization to Release Information. I authorize the disclosure of any or all information in my medical or accounting record, including information regarding the diagnosis or treatment of HIV, AIDS, mental illness, or substance abuse, to any person, corporation or agency responsible for determining the necessity, appropriateness, payment or other matters related to CoxHealth treatment or services. This includes, but is not limited to, insurance carriers and companies, managed care plans, health maintenance organizations, preferred provider organizations, workers' compensation carriers, welfare agencies, Medicaid, or Medicare and its intermediaries and carriers, or my employer, which may be necessary to process any claim related to this hospitalization or outpatient service. I further agree that if my injury is work-related, I authorize the disclosure of my medical record related to my work-related injury to my employer or employer's representative.

Assignment of Benefits. I assign to CoxHealth or the Covered Entities listed below the benefits due to me for CoxHealth services from my insurance carrier or company, managed care plan, health maintenance organization, Medicaid, or Medicare and its intermediaries and carriers.

Medicare Beneficiaries. I authorize CoxHealth to obtain information from the Social Security Administration regarding my entitlement to benefits and my health insurance claim numbers.

Financial Obligation. I agree that I am financially responsible for payment of all amounts due for services provided by CoxHealth and the physicians. I further understand that I am responsible to pay for such services regardless of whether I have insurance coverage or whether other parties may also be responsible for paying for my care. I will not be responsible to pay for such services rendered if my financial obligation is waived by contractual agreements between CoxHealth and my insurer, or if prohibited by applicable state or federal laws or regulations. In the event of collection, I agree that the cost of collection, including reasonable attorney's fees and court costs, will be included as part of my financial obligation to CoxHealth and the entities listed below. This agreement shall be governed by Missouri law, and I hereby waive venue and agree that venue shall be appropriate in Greene County, Missouri.

◆ **Covered Entities.** This Authorization, Financial Obligation and Consent Form applies to Lester E. Cox Medical Centers ("CoxHealth") facilities, departments and clinics including Ferrell-Duncan Clinic as well as its affiliated entities including Burrell, Inc.; Oxford Healthcare; Cox HPS of the Ozarks, Inc.; Primrose Place, Inc.; Cox-Monett Hospital, Inc.; Ozark Neuro Rehab; Cancer Research for the Ozarks, (all entities collectively referred to as "CoxHealth") and the following hospital-based independent provider groups as applicable: Ozark Anesthesia Associates, Inc.; Litton & Giddings Radiological Associates, Inc.; Pathology Services of Springfield, Inc.; Emergency Physicians of Springfield, Inc.; EJW Anesthesia, Inc.; Visionary Imaging, Inc. (all entities and hospital based groups collectively referred to as "Covered Entities") and any other service provider or facility that your insurance company has negotiated with to provide a particular health service, or that you have requested. **I UNDERSTAND I MAY RECEIVE SEPARATE BILLS FROM EACH ENTITY NAMED IN THIS PARAGRAPH.**

◆ **Consent for Treatment.** I agree, request and authorize the employees or, contractors of CoxHealth and its Covered Entities to provide healthcare services to me and further consent to any examination, tests or procedures that may be advisable or necessary for routine diagnostic purposes or to diagnose or treat my medical condition. I realize that among those who attend to patients at CoxHealth and its Covered Entities are medical, nursing and other healthcare personnel in training who may be present and participating in my care as part of their education. I authorize the taking of photographs or other images of me or parts of my body for use in medical evaluation and education. I am aware that the practice of medicine is not an exact science and understand that no promise, guarantee or warranty has been made regarding the results of the examination or treatment I receive. I understand that the employees and contractors of CoxHealth and the Covered Entities do not routinely test patients for hepatitis or human immunodeficiency virus (HIV). I agree to have my blood tested for hepatitis or HIV infection, if my physician determines that it is necessary or if an employee, provider, volunteer or contractor of CoxHealth or its Covered Entities is exposed to my blood or bodily fluids. If my blood indicates infection, my physician will be notified as well as any other individual, entity or agency required by law.

I certify that I have read all parts of this Authorization, Financial Obligation and Consent Form, accept all its terms and conditions, that all representations made by me are true, and that a copy of this form is effective and valid as the original. This Authorization, Financial Obligation and Consent form is good for one year unless the patient or guardian revokes it in writing.

x Signature: ______________________ ________ *Date* Relationship, if signed by other: ______________ *(Parent, if minor child, or guardian)*

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Authorization for Verbal Communication

Confidentiality is very important to us. Often family members inquire about health status or wish to be involved in the patient's treatment. Sometimes age specific conditions require that a family member or others assist with your health care. **Unless you tell us otherwise, our standard policy is to NOT provide any information.** By completing this form, you give us permission to **verbally** discuss your information with whomever you choose. Feel free to discuss this with your physician or other clinic staff member.

***Note:** For patients who are minors, both parents may have access to all information unless forbidden by divorce decree.*

Patient Name ______________________ Date of Birth ______________

Name: ______________________ **Relationship:** ____________ **Phone:** ______________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________________ **Relationship:** ____________ **Phone:** ______________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________________ **Relationship:** ____________ **Phone:** ______________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________________ **Relationship:** ____________ **Phone:** ______________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

Name: ______________________ **Relationship:** ____________ **Phone:** ______________

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

I, the undersigned, authorize and give permission to my health care team to VERBALLY discuss the indicated information above with the individual(s) I have listed. I understand that this form does NOT give the listed individual(s) permission to make health care decisions for me. I understand that I am responsible for notifying this office, in writing, of any changes to this authorization.

x Signature ______________________ ____________ Relationship if signed by other ______________

Date (Parent, if minor child, or guardian)

For NEW Patients Only **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The Notice of Privacy Practices of CoxHealth sets forth the ways in which my personal health information may be used or disclosed by CoxHealth, and outlines my rights with respect to such information. I acknowledge that on today's date:

☐ **I RECEIVED** a copy of the CoxHealth Notice of Privacy Practices ☐ **I DECLINED** a copy of the CoxHealth Notice of Privacy Practices

x Signature ______________________ ____________ Relationship if signed by other ______________

Date (Parent, if minor child, or guardian)

Health History SCREENINGS
Must be completed fully for screenings to be done

Childs Name:
Date of Birth:
Age and Grade:
Any known drug allergies:
Name of regular doctor/provider:

PAST MEDICAL HISTORY

Type of birth (Normal? C section(list reason)? Premature? Full term?)
NICU? Yes NO
Any Chronic illnesses?
Any Daily medications?

Surgical History:
Any Surgery? Describe: Age of surgeries: Please list separately if needed

SOCIAL HISTORY:

Who does child live with? How many siblings in the home?

FAMILY HISTORY:

List relative who has asthma, diabetes, premature cardiac arrest or any hereditary disease

Review Current Health Concerns:
Please answer either no problem or describe problem in each area.

General Health:

Skin:

Head, ears, nose and throat:

Respiratory:

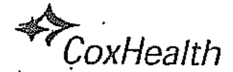
Cardiac:

Gastrointestinal:

Urinary:

Endocrine:

Musculoskeletal:



Patient Name:________________________ Date of Birth:______________

NEEDS ASSESSMENT
PEDIATRIC

Date Completed: ______________

Informant *(Form Completed by)*	Relationship to Child

Primary Language *(What language are you most comfortable speaking?)*

O English
O Spanish
O Other; specify which language

Do you have any spiritual, cultural or ethnic beliefs that you wish for us to know?	O yes	O no	If yes, specify
Do you have any physical or mental disabilities that require you to seek other's assistance in your child care?	O yes	O no	If yes, specify:
Who is the child's legal guardian(s)?	Specify		
Will a legal guardian come with your child for each visit? If no, a Minor's Consent for Treatment will be required for persons whom you authorize to accompany your child to any visit. *Ask staff for Consent for Treatment of Minors authorization.*	O yes	O no	
List 3 phone numbers where we can contact you with questions or information.	1. 2. 3.		

AUTHORIZATION FOR CONSENT TO TREAT A MINOR

I, ____, hereby authorize
(name and relationship to minor)

Chadwick R-1 School District
Chadwick, MO 65629
____ to consent to obtain
(name of person authorized to consent)

the following medical treatment for ______________________________:
(name of minor)

(Please check one)

_____all surgical and medical treatment; OR

_____Only the surgical and/or medical treatment listed below:

____.
(specify treatment)

This authorization shall be limited to the following time period:

____.
(time period)

If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

______________________________ ______________________________
Signature Date