COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
CASPER • DUBOIS • RIVERTON

Pt ID # _____

PATIENT REGISTRATION FORM

5000 Blackmore Road Casper, Wyoming 82609

Last Name	**First Name**	**Middle Initial**	**Preferred Name**
Date of birth	**Sex at Birth** □ Male □ Female □ Decline	**Mailing Address** **City** **State** **Zip**	
Home Phone	**Cell Phone**	**What is your marital status?** □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	
Social Security Number	**Email Address**	**Preferred Pharmacy**	

RESPONSIBLE PARTY INFORMATION

First/Last Name	**Employer**		**Social Security #**
Street address	**City**	**State**	**Zip**
Date of birth	**Gender** □ Male □ Female	**Phone Number**	**Patients Relation to Guarantor**

INSURANCE

Insurance company	**Employer**	
Policy holder's first and last name	**Policy holder's date of birth**	**Policy holder's social security #**

HEALTH CENTER FUNDING INFORMATION

In order to continue the variety of services that we offer here at CHCCW and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

What is your household annual income?
□ <$10,000
□ $10,000-14,999
□ $15,000-19,999
□ $20,000-29,999
□ $30,000-49,999
□ $50,000-79,999
□ $80,000 -99,999
□ $100,000 +

How many people in your family? (yourself, spouse and minor children under 18 years) _____

Veteran Status:
□ Veteran
□ Not a veteran

Homeless Status:
□ Shelter □ Street
□ Transitional Housing
□ No

Agricultural Status over the last 3 years:
□ Migrant □ Seasonal □ No

Student Status:
□ Student full time
□ Student part time

Employment Status:
□ Employed full time
□ Employed part time
□ Unemployed
□ Retired
□ Disabled

Employer Name:
_____

Employer Address:
_____

Racial Group(s):
□ African American/Black
□ Asian
□ Caucasian/White
□ Multiracial
□ Native American/Alaskan Native
□ Pacific Islander
□ Other:

Referral Source:
□ Billboard
□ Radio
□ Business/Agency
□ Friend or Family
□ Fair/Festival/Event
□ Hospital/Clinic
□ Internet Search
□ Social Media
□ Newspaper

What is your gender identity? **Only if over 12 years of age
□ Male
□ Female
□ Transgender Male/Trans Man/FTM
□ Transgender Female/Trans Woman/MTF
□ Gender Queer
□ Chose not to disclose

Preferred Language:
_____

Do you need an Interpreter?
□ Yes □ No

Ethnicity:
□ Hispanic/Latino/Latina
□ Non-Hispanic/Latino/Latina

Do you think of yourself as: **Only if over 12 years of age
□ Lesbian, gay, or homosexual
□ Straight or heterosexual
□ Bisexual
□ Something else
□ Don't know
□ Chose not to disclose

What pronouns do you use? **Only if over 12 years of age
□ he/him
□ she/her
□ they/them

EMERGENCY CONTACT INFORMATION

Emergency contact	**Relationship to patient**	**Phone number**

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CONSENT TO TREATMENT:

I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Community Health Centers of Central Wyoming (CHCCW). I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the Community Health Centers of Central Wyoming clinic sites. I may cancel this consent in writing.

I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the hospital assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or pre-recorded messages in contacting me.

Signed: **X**_____ _____

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (print) Relationship

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:

I authorize CHCCW to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also CHCCW may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Community Health Centers of Central Wyoming for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Community Health Centers of Central Wyoming account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: **X**_____ _____

Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____

Full name (print) Relationship

PROTECTED HEALTH INFORMATION DESIGNEE:

I understand that the individuals identified below will be treated by Community Health Centers of Central Wyoming as individuals involved directly in my care or my child's care, and as such CHCCW will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments, bringing a minor child for medical treatment, and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: _____ Relationship to Patient: _____

Name of Designee: _____ Relationship of Patient: _____

☐ *I decline to provide a protected health information designee contact for myself or my child at this time.*

Patient Signature/Parent/Legal Guardian_____ Date: _____

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AS A PATIENT, I AGREE TO THE FOLLOWING:

- I agree to treat staff and clients of CHCCW with dignity and respect.
- I will arrive to my appointment on time.
- I will cancel appointments at least 2 hours before or it will be considered a "No Show". Repeat "No shows" could result in you losing privileges to schedule future appointments.
- I have been given the opportunity to ask any questions I have about my care through CHCCW.
- I can request a copy of all authorization documents such as Notice of Privacy Practices (HIPAA), Patient responsibilities, and CHCCW Responsibilities and Duties.
- I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

Signed: **X**_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____
Full name (print) Relationship

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COMMUNITY HEALTH CENTERS OF CENTRAL WYOMING
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FINANCIAL AND APPOINTMENT POLICY

Thank you for choosing Community Health Center of Central Wyoming (CHCCW) Dental Clinic as your dental care provider. We strive to offer quality and affordable dental services provided by qualified professionals. It is important that you understand your financial and appointment responsibilities, recommended treatment plan, the costs associated, and that some dental procedures may require referral to another dentist or specialist.

Treatment Plan: When you are scheduled for a Comprehensive Exam our dentist will perform an evaluation of your dental and oral health needs and develop a treatment plan that will address those needs. The dentist has authorized the dental staff to perform some services required to provide the diagnosis and treatment plan. The dental clinic requires that you see the hygienist according to your prescribed maintenance schedule in order to continue to be treated by the dentist. Repeated visits may be required for completion of this treatment plan. Your dentist will discuss the details of your treatment plan with you and give you a copy upon request.

Dental or Specialist Referral: Your treatment plan may require services that cannot be provided at the CHCCW Dental Clinic. In this case, you will be referred to another dentist or specialist for completion of your treatment plan. Payment arrangements must be made with the dentist/specialist office prior to your first visit. Sliding fees will not apply to outside providers.

Payment Expectations: The CHCCW Dental Clinic provides many options for dental patients to minimize the financial barriers to healthy and complete dental care. As a courtesy the office staff will file to all insurances, including Medicaid. However, you will be expected to pay your estimated co-insurance at the time of service. If your insurance or Medicaid does not pay for part or all of the services, you are responsible for the billed amount. We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. If you show up without payment, your appointment will be rescheduled. True emergencies will be handled on a case-by-case basis.

Dental Insurance and Medicaid: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You understand that all charges are ultimately your responsibility even if insurance does not pay. Please be aware that some, and perhaps all, of the services provided may not be covered services and not considered reasonable and customary under the terms of your insurance policy. If you do not have insurance, CHCCW will help find an available financial assistant program. If none is found, CHCCW offers the sliding fee discount for those who qualify, please ask the receptionist about the requirements. We do everything possible to keep our services affordable.

Emergencies: The CHCCW Dental Clinic will provide emergency dental services whenever possible. However, referral to another Dentist, Specialty, or Primary Care provider may be necessary to accommodate your emergent needs, based on the severity of the emergency. When there is not availability on our schedule, we will keep a waiting list for those emergencies that want to schedule with our clinic. Or, we will schedule your for the next available time, which could be several days.

Lab Charges: Some dental procedures require the use of an outside Lab for services such as dentures, bridges, crowns, etc. You must pay in advance for Lab services. If you are on a sliding scale, the charges for Laboratory cases are discounted differently than the normal discounted percent for your sliding scale.

Scheduling, Cancelling and No-Showing for Appointments: The CHCCW Dental Clinic will make every effort to schedule your appointments according to your recommended treatment plan. Check-in is twenty (20) minutes prior to your scheduled appointment time. An appointment must be cancelled at least two (2) hours prior to the time of the appointment or will be considered a "No Show". Patients who no-show for dental treatments will not be seen until they pay a twenty-five dollar ($25.00) late fee, which will not be billed to insurance, payment is required before scheduling next appointment. Patients that arrive ten (10) minutes late for scheduled appointment will be asked to wait in the lobby while the receptionist checks with the provider to determine if the patient can be seen at that time.

CHCCW HIPAA / Patient's and Provider's Rights and Responsibilities. The Dental Clinic provides copies of these policies. Patient acknowledges they have read and understand these policies.

□ ***I HAVE READ*** the CHCCW Dental Clinic Financial and Appointment Policy and understand the services provided and my responsibilities as a dental clinic patient. I authorize the dentist and the dental staff to provide services to me.

Last Name _____ First Name _____

Signature of Patient or Guardian _____ Date _____

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UNATTENDED CHILD POLICY ACKNOWLEDGMENT

Your cooperation will be needed to help us provide the best possible dental care to your family. Please read our policies below and initial next to each statement.

_____ I understand and am aware it is a courtesy to allow others to be present during treatment and only one (1) parent or authorized adult (i.e. guardian, power of attorney, spouse, etc.) will be allowed into the treatment area, there will be no siblings.

_____ I understand and am aware that clinic staff will not be responsible for unattended children in the waiting area and it is my responsibility to find appropriate supervision/care for my children if I choose to be present in the treatment area.

_____ I understand and am aware children may not be left in the waiting area while I am being treated and I must reschedule my appointment if I do not have appropriate supervision/care for the children.

_____ I understand and am aware that in order to respect patient and staff privacy, I will remain seated outside of the operatory at all times and will avoid wandering through the patient treatment area.

_____ I understand and am aware cell phone conversations are prohibited while in the treatment area. If my conversation or actions are loud and/or disruptive, I will be asked to return to the waiting area.

_____ I understand and am aware it is prohibited to take photographs while in the treatment area.

_____ I understand and am aware to refrain from conversation with the doctor and dental assistant while they are performing treatment. If I have any questions or concerns, I will try to address them at the beginning or end of the treatment encounter.

_____ I understand and am aware that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and/or dentist to hold the patients hands, stabilize the head and/or control leg movements for their safety. I also understand that it is best to refrain from attempting to help control behavior and to stay seated.

_____ I understand and am aware in order to provide the delivery or safe dental care a referral to a Pedodontist may be suggested and appropriate contact information will be provided.

By signing below I confirm that I have read and understand this form or it was read and explained to me and all my questions have been answered to my satisfaction.

_____

Patient/Guardian Signature Date

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DENTAL CLINIC – PATIENT MEDICAL & DENTAL INFORMATION

Patient Name _____ Date of Birth _____ Patient ID _____

MEDICAL INFORMATION

	Yes	No
Are you now under the care of a physician? If so, Physician Name_____ Phone:_____	☐	☐
Females: Could you be or are you pregnant?	☐	☐
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how long? _____	☐	☐
Have you used tobacco in the past?	☐	☐
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐
Are you taking or scheduled to begin taking either of the medications Alendronate (Fosamax®) or Risedronate (Actonel®) for Osteoporasis or Paget's Disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, multiple myeloma or metastatic cancer? Date treatment began:	☐	☐

	Yes	No
Active Tuberculosis?	☐	☐
Persistent Cough greater than a three (3) weeks duration or Cough that produces blood?	☐	☐
Have you had a serious illness, operation or been hospitalized in the past five (5) years?	☐	☐
Are you taking or have you recently taken any prescription or over-the-counter medicine(s)?	☐	☐
Have you ever had an allergic reaction to local anesthetic?	☐	☐

Please *list all medicines* including aspirin, vitamins, natural or herbal preparations and/or diet supplements:

_____
_____
_____
_____

List all DRUG ALLERGIES (Penicillin, latex, codeine)

_____
_____
_____

	Yes	No		Yes	No		Yes	No
Anemia ……..	☐	☐	Hemophilia ……..	☐	☐	Mitral Valve Prolapse …..	☐	☐
Alcohol Use ……...	☐	☐	Asthma …….	☐	☐	Organ Transplant …….....	☐	☐
Aneurysm ……..	☐	☐	Blood Disease ……..	☐	☐	Pancreatitis …….....	☐	☐
Angina/Chest Pain …….	☐	☐	Cancer ……..	☐	☐	Pneumonia …….....	☐	☐
GERD/Chronic Heartburn …….	☐	☐	Coumadin …….	☐	☐	Respiratory Problem ….....	☐	☐
Pacemaker ……..	☐	☐	Diabetes ……	☐	☐	Rheumatic Fever …….....	☐	☐
Artificial Heart Valve ……	☐	☐	STD/Venereal Disease …….	☐	☐	Skin Problem/Rash …….....	☐	☐
Previous infective Endocarditis ……...	☐	☐	Eating Disorder …..…..…..…...	☐	☐	Stomach/Intestinal Prob….	☐	☐
Damaged Valves in transplanted Heart ……..	☐	☐	Emotional Problems …….	☐	☐	Stroke …….....	☐	☐
Congenital Heart Disease ……..	☐	☐	Emphysema …..…..…..…..…...	☐	☐	Surgery …..…..…..….....	☐	☐
Unrepaired Cyanotic CHD ……	☐	☐	Epilepsy/Seizure ……..……	☐	☐	Thyroid Disease …….....	☐	☐
Repaired (completely) in last six (6) months …….	☐	☐	Fibromyalgia ……	☐	☐	Tumor or Growth …….....	☐	☐
Repaired CHD with residual defects ……..	☐	☐	Hepatitis A, B, or C ……..	☐	☐	Glaucoma …….....	☐	☐
			Herpes/Cold Sore …..…..…..…	☐	☐	Sleep Disorder …..….....	☐	☐
			High Blood Pressure ……	☐	☐	Hospitalization …….....	☐	☐
			HIV/AIDS ……	☐	☐	Kidney Problems …….....	☐	☐
			Heart Murmur ……..	☐	☐	Liver Problems …….....	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐

Name of physician or dentist making this recommendation _____ Phone: _____

DENTAL INFORMATION

	Yes	No		Yes	No
Do your gums bleed when you brush/floss?	☐	☐	Do you have earaches or neck pain?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	Are you currently experiencing dental pain or discomfort?	☐	☐
Does food or floss catch between your teeth?	☐	☐	Do you have sores or ulcers in your mouth?	☐	☐
Is your mouth dry?	☐	☐			
Have you had any periodontal (gum) treatments?	☐	☐	Date of your last dental exam: _____		
			What was done at that time: _____		
Have you ever had orthodontic (braces) treatments?	☐	☐	Date of last dental x-rays:_____		

What is the reason for your dental visit today? _____

How do you feel about your smile?

To the best of my knowledge the above information is true and correct. I understand this information will be kept confidential. I will inform the doctor of any changes in my health and medical condition, or if my medicines change.

Patient/Guardian Signature: _____Date:_____ Staff Initials: _____