Basic Demographics Patient Information

Demographical Information

Name: (Last) _____ (First) _____ (MI) ____ Date of Birth: _____

Social Security Number: _____ Gender: (Circle One) Male Female

Address: _____ City: _____ State: ____ Zip: _____ County: _____

Phone Numbers: Cell: _____ Can you receive text messages? YES NO Home: _____

Work: _____ Message Phone: _____ Email Address: _____

Preferred way of communication: (Circle One) Cell Phone Home Phone Work Phone Message Phone Email

Do we have permission to contact you and leave messages on your preferred communication method? Yes No

Marital Status: (Circle One)
-Single -Married -Separated -Divorced -Widowed

Race: (Circle One)
-Asian -African Am./Black -Caucasian/White
-Am. Indian/Alaska Native -Native Hawaiian/Other Pac. Islander -Other

Ethnicity: (Circle One)
-Hispanic or Latino -Not Hispanic or Latino

Veteran Status: (Circle One)
-Veteran -Non-Veteran -Unknown

Pharmacy Information

We offer a prescription discount with both Kroger locations in Marion, Wal-Mart in Marion, and Kroger in Mt. Gilead

Pharmacy: _____ Location: _____

Legally Responsible Parent or Guardian Information (If applicable)

Name: (Last) _____ (First) _____ (MI) ____ Date of Birth: _____

Social Security Number: _____ Gender: (Circle One) Male Female

Relationship to patient: _____ Legal custodian: YES NO Residential parent: YES NO

Insurance Information

Insurance Company Name: _____ Policy Holder's Name: _____

Patient's Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Policy Holder's Phone Number: _____
Member ID: _____ Policy Number: _____ Group Number: _____

Emergency Contacts

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

We offer the following services and care at the listed locations:
Marion: Primary Medical, Dental, Counseling, Optical, Chiropractic services
Mount Gilead: Primary Medical, Dental, Counseling
Galion: Primary Medical, Dental, Counseling

Basic Demographics Privacy Practices, and Rights and Responsibility

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Notice of Privacy Practices Acknowledgement

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I received a copy of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my PHI. I have read the document and understand the information.

Notice of Rights and Responsibilities Acknowledgement

I understand that this organization has the right to change its NOTICE OF RIGHTS AND RESPONSIBILITIES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF RIGHTS AND RESPONSIBILITIES. I received a copy of your NOTICE OF RIGHTS AND RESPONSIBILITIES containing a more complete description of the guidelines of rights and responsibilities I have while a patient. I have read the document and understand the information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Basic Demographics — Self-Declaration of Income

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Are you eligible for a DISCOUNT?
Lower your healthcare costs with us!

How many people are in your household: _____

(Number of people you are financially responsible for in your home or number of people you claim on your taxes.)

How much is your TOTAL household monthly income?

(Please circle an amount closest to your monthly income)

0	500	1000	1500
2000	2500	3000	3500
4000	4500	5000	Other: _____

If we find you eligible for any discount or assistance program we offer, verification of all income must be on file before any benefit could begin.

Basic Demographics — Community Survey

How did you hear about us? Please circle all those that apply:

Facebook Billboard Website Radio Newspaper Pamphlet Friend/Relative

Other: (Please Specify) _____

What do you like about us? Please circle all those that apply:

Staff Cleanliness Location Speed Atmosphere Cost

Other: _____

How did you arrive at your appointment today? Please circle one of the following:

Drove own vehicle Friend/Relative Bus/cab Walk

Do you have any suggestions to improve your visit with us?

_____

_____

Thank you for taking the time to complete our survey. Your input is greatly appreciated.

Optical History _____ Child or Adult

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical and vision history.
Name: (Last) _____ (First) _____ (Middle) _____ Date of Birth: _____ Age: ____

Do you have a Primary Medical Provider (Family Doctor): ___ YES ___ NO Do you have a Dentist: ___ YES ___ NO
Do you have a Therapist/Counselor: ___ YES ___NO Do you have a Chiropractor: ___ YES ___ NO

Eye Exam History **_____ Patient denies any past eye exams**

Last eye exam: _____ Location: _____ Doctor/Provider: _____
Do you wear contact lenses? ___ YES ___ NO If yes, ___ Soft contacts ___ Gas perm contacts Do you sleep in your contacts? ___ YES ___ NO

Medical History

Last physical exam: _____ Location: _____ Primary care physician: _____

Have you ever been diagnosed with the following: ____ Patient denies any past illness

Arthritis	Chronic Bronchitis	Depression	Heart Disease	Lupus	Seizures
Asthma	COPD	Diabetes	High Blood Pressure	Migraines	Stomach Ulcers
Bladder Problem	Decreased Hearing	Epilepsy	High Cholesterol	Multiple Sclerosis	Thyroid Dysfunction
Cancer	Dementia	GERD	Kidney Problems	Psoriasis	Other:

Are you currently experiencing any of the following:

Fever	Excess Thirst	Sinus Problems	Vomiting	Bladder Problems	Other:
Weight Change	Excess Urination	Sore Throat	Headaches	Depressed Mood	Other:
Chest Pain	Rash	Vertigo	Joint Pain	Bruising	Other:
Irregular Heartbeat	Skin Sores	Abdominal Pain	Cough	Allergies	Other:

Have you ever been exposed to the following: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis
Are you currently pregnant or breast feeding? ___ YES ___NO

Past Surgical/Injury History – _____ Patient denies any past surgeries
Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred,

_____
_____
_____

Medications – Please list all medication you are currently taking (including over the counter, vitamins and supplements)
_____Patient denies any medications

_____
_____
_____
_____

Allergies – Please list all food, medication, and environmental allergies _____ Patient denies any allergies

_____
_____
_____

Family History – Has any blood relative had any of the following: (Leave blank if uncertain)

Condition	Relationship to you	Condition	Relationship to you	Condition	Relationship to you
Cancer Type:		Thyroid Disease		Glaucoma	
Diabetes Type:		Macular Degeneration		Cataracts	
Heart Disease		Retinal Detachment		Blindness	
High Blood Pressure		Arthritis		Lazy Eye	

Social History

Tobacco: ____ Never ____Minimal ____YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)
Alcohol: ____ Never ____Minimal ____ Less than 10 a week, ____ More than 10 a week, _____ QUIT _____ Years ago
Illicit Drugs: ____ Never ____Minimal ____ YES _____ QUIT _____ Years ago
Education Level: ____ High School ____College ____ Post Graduate ____ Other
Occupation: _____ Military Service: ___ YES ___ NO
Do you drive? ___ YES ___ NO Do you have trouble with driving vision? ___ YES ___ NO Do you have trouble with night vision? ___ YES ___ NO
Do you have difficulty with light sensitivity or glare? ___ YES ___ NO Do you work on a computer? ___ YES ___ NO
Do you wear protective eyewear for work? ___ YES ___ NO Do you require protective eyewear for sports? ___ YES ___ NO

Signature: _____ Date: _____

Optical Release HIPAA Authorization

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize **Center Street Community Health Center (CSCHC)** to use and disclose my following **Protected Health Information (PHI)** listed below for the purposes listed elsewhere on the page.

List individuals you would allow us to share medical information with if necessary.

Name of entity or person	Relationship to patient	Telephone Number

Upon supplying proof of identity by showing acceptable form of photo identification, the above listed person(s) may have access to my: medications, prescriptions, documentation in sealed envelope, appointment time, and any life-threatening, emergency information.

This Protected Health Information (PHI) is being given or disclosed for the following purpose(s): Continuity of Care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Center Street Community Health Center Corporate office. I understand that revocation is not effective to the extent that my provider has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the provider from a third party.

If the disclosure concerns a patient in an alcohol or drug abuse program, the following notice shall accompany the disclosure: This information has been disclosed to you from our records protected by federal confidentiality rules (442CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I SPECIFICALLY AUTHORIZE THE DISCLOSURE TO & RELEASE FROM THE ABOVE NOTED AGENCIES REGARDING THE INFORMATION BELOW:

___ Mental Health Information- current diagnosis & medication list ___ Substance abuse (including alcohol/drug abuse)

___ STD related information (STD testing) ___ HIV related information (AIDS related testing)

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Able to Bring Child/Ward to Appointment Consent

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

I give consent to the following representative(s) to bring my child/ward to his/her visits:

Representative Name	Relationship to patient	Telephone Number

I understand that I should not sign this consent form if there is any information that may be in my child's/ward's healthcare record that I do not want the representative(s) to know.

I understand during my child's/ward's visit that all personal health information within the child's/ward's healthcare record may be discussed with the representative. A follow up visit will be made if my child/ward has a healthcare condition by history or exam that warrants a follow up appointment. The provider may request a parent/guardian be present at the follow-up visit. The provider may choose to not complete a physical form until the healthcare issues are addressed at the follow-up visit with the child/ward and the parent/guardian present if the healthcare condition warrants a follow up appointment. The provider may decide not to perform immunizations, tests, or procedures during the visit if the provider does not feel the representative is able to give enough healthcare history to provide the best care for my child/ward. Pregnancy care and sexually transmitted diseases may be treated during the visit without parental or representative consent as designated by state law. I further understand that confidentiality between the minor and Center Street Community Health Center, Morrow Family Health Center, and Galion Family Health Center professionals will be ensured in specific areas designated by law and will not be discussed with the parent/guardian unless the minor agrees or is determined to be a threat to themselves or another person.

By signing this consent form, I give my consent to the representative(s) listed above to sign for any necessary care for my child/ward upon recommendation of the provider. I further authorize Center Street Community Health Center and all satellite locations to release information regarding my child's/ward's treatment to the third-party payor or others for purposes of billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality, and my insurance carrier or medical assistance to be billed for services received.

I give permission to all representative(s) listed to bring my child/ward for any services rendered at the following locations:

Center Street Community Health Center:
___ Medical
___ Dental
___ Behavioral Health
___ Optical

Morrow Family Health Center:
___ Medical
___ Dental
___ Behavioral Health

Galion Family Health Center:
___ Medical
___ Dental
___ Behavioral Health

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

We will be unable to serve as your provider if you do not agree to the terms within this consent form.

Optical Release Treatment & Dilated Fundus Exam Consent

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Treatment Consent

I understand that treatment provided to me by any optical, medical, dental, nursing students, LISW, or PsyD staff will be properly supervised by a licensed practitioner. I am giving permission for any exams, tests, or other services that the provider believes are needed. Center Street Community Health Center makes sure that all staff who need to be licensed by the State of Ohio have the proper credentials. I understand and agree that I will participate in the planning of my care, treatment, and/or services. I understand that I may stop care, treatment, and/or services at any time. I also understand that there are no guarantees that treatment will be successful.

CSCHC has the right to treat me without consent only in three situations:

1) Emergencies 2) When non-verbal communications show implied consent 3) When legally bound to treat.

Signature: _____ Date: _____

Information about the Dilated Fundus Exam

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply an entry way/opening to the inside of the eye. Looking through an *un-dilated* pupil is similar to looking into a room through a keyhole in the door. The doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door. The doctor gets a complete view of the inside of the eye.

A dilated fundus exam is recommended routinely at the time of your initial exam for baseline recording and usually every other full eye exam thereafter (about every 2 to 3 years). It should be completed annually if you have any of the conditions listed under **Benefits** below.

Benefits

Dilation allows the doctor a better view of the peripheral retina for disease. It is highly recommended if you or your family have a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment/tears), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, “curtain or veil-like” obstruction of vision, a sudden onset of many “floaters”, or flashing lights off to the side of your vision.

Risks

You may notice some blurring of vision and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. You may have difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read. In some rare cases, there may be redness or sharp pain because of induced ocular hypertension. If this happens, contact the doctor immediately.

I have read and understand the above information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Optical Release HIE Notice Consent

HIE Notice Language

I understand that Center Street Community Health Center participates in one or more Health Information Exchanges. My healthcare providers can use this electronic network to securely provide access to my health records for a better picture of my health needs. They, and other healthcare providers, may allow access to my health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the office administrator.

Signature: _____ Date: _____

Optical Reason for Visit

Patient Name: _____

Preferred Provider: _____

Main Reason(s) for today's visit:

1._____

2._____

Check all that apply:

- ○ Sick visit
- ○ ER/Urgent Care Follow-up Last ER/Urgent Care Visit: _____
- ○ Check-up
- ○ Need shots/Vaccines
- ○ Need Prescription Refills If so, which medications? _____

The American Medical Association supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior for the purposes of research into patient health.

Center Street Community Health Center, Morrow Family Health Center, and Galion Family Health Center are asking that all patients answer the following questions. The information is being collected for demographic purposes only and will ***NOT*** affect your care.

Do you think of yourself as:	**What was your sex at birth?**	**What is your current gender identity?**
○ Lesbian, Gay, or Homosexual ○ Straight or Heterosexual ○ Bisexual ○ Something Else ○ Prefer not to answer	○ Male ○ Female	○ Male ○ Female ○ Transgender Male/Female-to-male ○ Transgender Female/Male-to-Female ○ Other; please specify_____ ○ Chose not to disclose