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Douglas County Health Dept.

Registration Form

First Name: _____ **Middle:** _____ Last: _____ **Preferred Name:** _____

DOB: _____/_____/_____ **SSN:** _____/____/_____ **Primary Language:** English Spanish Other:_____

Please circle one (As applicable): Jr. Sr. II III IV V

Gender at Birth: Male Female **Current Gender Identity:** Transgender Male Transgender Female Other

Marital Status: Single Married Divorced Widowed

Employment Status: Employed Unemployed Student Other

Race: Asian Black/African American Native American/Alaskan Native Native Hawaiian Pacific Islander White/Caucasian

Ethnicity: Hispanic/Latino Not Hispanic/Latino Mexican American Mexican Spanish Declined to Answer

Address: _____City: _____State: _____ Zip: _____

Phone Number: _____ Alternate Phone: _____ Email: _____

Would you prefer text message reminders to the phone number(s) provided? Yes No

For clients < 18 years old or > 18 years old with a conservator, please complete the following:

Parent/Guardian First & Last Name: _____ DOB: _____ Phone: _____

Parent/Guardian First & Last Name: _____ DOB: _____ Phone: _____

If client is over 18 years old who has a conservatorship, please discuss this information with our staff.
DCHD may request documentation regarding the guardian or conservator as proof to consent to care and billing.

Emergency Contact Information:

Name (First & Last): _____ DOB: _____ Phone Number: _____Relationship: _____

By providing this information, you (client or parent/guardian) acknowledge pertinent health information may be shared with the emergency contact listed as applicable to the scenario in which DCHD personnel use judgement to call the listed emergency contact. Initial: _____

Insurance (As Applicable):

If you would like Douglas County Health Department to bill insurance as contracted for the cost of services rendered at Douglas County Health Dept, please provide the reception desk with a copy of an existing insurance card eligible for the date of service.

If uninsured, please complete the "Financial Assistance Application" document.

Patient Health Questionnaire-2:

Over the **last 2 weeks**, how often have you (client) been bothered by the following problems?

1. Little interest or please in doing things? Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)
2. Feeling down, depressed or hopeless? Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)

Assignment of Benefits: I (client or parent/guardian) hereby assign all my rights, interests and claims for all insurance reimbursement and all benefits payable under Medicare, Medicaid and all other insurance policies and health benefits to

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Douglas County Health Department for the services, treatments and/or medications rendered or provided by Douglas County Health Department ("Assignment"). I request payment of associated benefits and insurance (medical, dental, etc.) reimbursement to Douglas County Health Department. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. Initial: _____

Authorization to Release of Information: I hereby authorize Douglas County Health Department to release all medical information to my insurance company, employee insurance group, health plan, Medicare/Medicaid program, its insurance carriers or intermediaries or the Social Security Administration ("Authorization"). Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Douglas County Health Dept all plan documents, summary of benefit descriptions, insurance policies, and/or settlement information upon written request from Douglas County Health Department to claim such medical benefits. The assignment and authorization are effective, valid and enforceable against all my current and future insurance companies, employee insurance groups, health plans, Medicare/Medicaid programs, its insurance carriers or intermediaries, unless I revoke this Assignment and Authorization by notifying Douglas County Health Department in writing of such revocation. Any such written revocation is effective from the date of receipt by Douglas County Health Department. A copy of this Assignment and Authorization is to be considered as valid and effective the same as the original. By initializing, I fully understand and agree to this assignment and authorization. Initial: _____

Notice of Privacy Practices Acknowledgement: I understand that the Notice of Privacy Practices document is available to me at the location(s) myself or my dependent receives health care services. By initialing this statement, I confirm I am the client or parent/legal guardian of the above listed client and am authorized to give this consent. This consent will be in effect for one year from the date signed. Initial: _____

Medical History Release of Information Consent: By signing this consent, I give Douglas County Health Dept permission to collect and give my pharmacy and my health plan permission to disclose information about my prescriptions that have been filled at any pharmacy or that are covered by any health insurance plan. This includes any prescription medications prescribed to me by Douglas County Health Dept clinicians and/or other clinical staff at other organizations. This information will become part of my medical record. This consent is valid and effective unless I revoke this consent by notifying Douglas County Health Dept in writing of such revocation. Any such written revocation is effective from the date of receipt by Douglas County Health Dept. A copy of this consent is to be considered as valid and effective, the same as the original. Initial: _____

Consent to Use of Electronic Health Record and Communication: If I provide Douglas County Health Dept with my cell phone number, I hereby give Douglas County Health Dept my express consent to call and/or text message my phone using automated technology and/or pre-recorded voice, including but not limited to appointment reminders and collection on account balances. I understand that I am not required to agree to such calls and/or text messages to my cell phone as a condition of receiving goods or services at Douglas County Health Dept. I further understand that text messages may not be a secure method of communication and accept the risk of transmitting my health information via text messages. This consent is valid and effective unless I revoke this consent by notifying Douglas County Health Department of such revocation. Any such revocation is effective from the date of receipt by Douglas County Health Dept. A copy of this consent is to be considered valid and effective, the same as the original. I understand that Douglas County Health Dept utilizes an electronic health record system for scheduling, documentation, and quality care provision of the various services offered within the organization. I understand unless I have completed an opt-out form for all my records to be maintained in a paper format, then my health information will be stored within a secure electronic health record system. An opt-out form must be completed annually if requested. Initial: _____

By signing below, I acknowledge that I have read, understand, and agree to all the above initialized sections of this consent, authorization, and agreement form provided by Douglas County Health Department. This consent will be in effect one year from the date signed.

Client or Parent/Guardian Signature: _____ Date: _____

Client Name (First & Last): _____ Date: _____

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Consent for Treatment/Services

The following professional staff may be involved in your care provided at the Douglas County Health Department as applicable to their individual scopes of practice: Advanced Practice Registered Nurse (APRN), Certified Medical Assistant (CMA), Community Health Worker (CHW), Dental Assistant, Doctor of Dental Medicine (DMD), Licensed Clinical Professional Counselor (LCPC), Licensed Clinical Social Worker (LCSW), Registered Dental Hygienist (RDH), and/or Registered Nurse (RN).

By signing below, I (client or parent/guardian) acknowledge consent for treatment for myself/the client for whom I am responsible:

I certify the information provided is the truth to the best of my knowledge. I give consent to exam and treatment by all qualified personnel at Douglas County Health Department, for the client. I consent to the client to receive dental, medical, access to social services and behavioral health care as deemed appropriate by qualified clinicians at the Douglas County Health Department. Examples of services in each category are available upon request.

In order for Douglas County Health Department staff to provide services, I authorize any relevant education institutions of the client's to release school records on a "need to know basis" to professional staff, and also for professional DCHD staff to release medical records to the client's educational institution and their health care provider as needed to assist in the treatment and/or continuity of care for the client. These records may include the following: immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, test results, medications, healthcare plans, or attendance information. Clinicians may participate in student success or attendance teams if needed.

Following Health Insurance Portability and Accountability Act (HIPAA) rules, Douglas County Health Department staff will use and share my Personal Health Information (PHI) for treatment of the client's health condition and maintaining the continuity of the client's care payment for health services provided to the client, and routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law

By signing this consent, I (client or parent/guardian) confirm I am authorized to give this consent. I understand this consent will be in effect for one year from this date for all services rendered at Douglas County Health Department unless otherwise revoked in writing.

Client or Parent/Guardian Signature: _____ Date: _____

Client Name (First & Last): _____ Date: _____

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Financial Assistance Application

As the Douglas County Health Department's mission is to provide accessible, affordable healthcare services to those who benefit from them and improve outcomes, we offer clinical services at a reduced cost for individuals who are uninsured, are unable to utilize their insurance benefits, or are unable to afford associated insurance related fees (co-pays, co-ins, deductibles, etc.). Applicants requesting financial assistance must complete the following information accurately and honestly to the best of their ability. Once you have completed the information requested, please see the reception staff for any other additional documents such as proof of income they may request. Such documents will be returned to you and are only requested for verification purposes.

By initialing this statement, I (client or parent/guardian of client) confirm understanding associated policies with available financial assistance programs at DCHD and will provide accurate income information to the best of my ability. I also understand that if information is found to be purposefully inaccurate, my ability to receive discounted services may by suspended or revoked at the discretion of the billing department. Initial: _____

Total Household Members: 1 2 3 4 5 6 7 8 9 10 > 10 Write-In: ____

Please list all members of your household:

Name (Including Yourself)	Relationship to You	DOB:	Gender at Birth

List any employer wages, earnings, or money received from self-employment to any member of your household as associated with receipt of income as well as any alimony, child support, pension, social security benefit, rental income, retirement, unemployment, veteran, or workers' compensation benefits you or any member of your household receive:

First Name:	Employer/Source of Income:	Gross Amount (Before Taxes):	Frequency: (Weekly, Bi-Weekly, Monthly, or Annually)

Client Name (First & Last): _____ Date: _____

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Medical and Family History

Client Name (First & Last): _____ **DOB:** _____

Are you under a physician's care now? Yes No If yes, please explain:

_____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications or substances? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Are you pregnant and/or trying to become pregnant? Yes No

Are you taking oral contraceptives? Yes No

Are you currently breastfeeding/nursing? Yes No

Are you taking any supplements?

Have antibiotics been prescribed to you prior to scheduled dental care in the past? Yes No

Are you allergic to any of the following: Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Other, list: _____

Do you have, or have you had, any of the following? (X before all that apply to YOU + Circle any a family member has or had.)

AIDS/HIV	Cortisone Medication	Hemophilia	Radiation Treatment(s)
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsilitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Venereal Disease
Convulsions	Heart Trouble/Disease	Psychiatric Care	Yellow Jaundice

Please list any other serious illness you have had that is not listed above:_____

To the best of my knowledge, this form has been completed accurately. I understand providing incomplete, inaccurate information pertaining to medical history may be dangerous to my health. I acknowledge it is my responsibility to inform Douglas County Health Department of any changes in medical history as applicable. Initial: _____

Client Name (First & Last): _____ Date: _____

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SDOH Screening

For Douglas County Health Department staff to best encourage healthy outcomes for all clients, we ask that you complete the following form so that we can connect you with available resources and supportive programs to benefit your health. The following answers will be kept securely in our electronic health record system and only used to refer clientele to applicable services.

At any point in the past 2 years, has season or migrant farm work been you/your family's main income? Yes No

Have you been discharged from the armed forces of the United States? Yes No

Family & Home:

What is your current housing situation?

I have housing I do not have housing (staying with others, hotel, shelter, living on the street, on a beach, in a car)

Are you worried about losing your housing? Yes No

Money & Resources:

What is the highest level of school that you have finished?

Less than high school diploma or GED High school diploma or GED More than high school diploma or GED

What is your main insurance coverage? None/Uninsured Medicaid Medicare Private Insurance

In the past year, have you or any household members been **unable** to get any of the following when it was **really needed**?

Food Utilities Clothing Child Care Medication/Health Care Phone Other:_____

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Yes, kept me from medical appointments Yes, kept me from non-medical appointments or work No

Social & Emotional Health:

How often do you see or talk to people that you care about and feel close to?

Weekly 1-2 Times Weekly 3-5 Times Weekly 5 Times Weekly

Stress is when someone feels tense, nervous, anxious, or can't sleep because their mind is troubled. How stressed are you?

Not at all A little bit Somewhat Quite a bit Very much

Additional Questions:

In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? Yes No

Are you a refugee? Yes No

Do you feel physically and emotionally safe where you currently live? Yes No Unsure

In the past year, have you been afraid of a partner or ex-partner? Yes No Unsure I have not had a partner in the past year

Are there any resources you would like assistance with? Yes No Unsure

If yes, list here: _____

Client Name (First & Last): _____ Date: _____