

Community Health Care Systems, Inc.

Wrightsville Tennille Sandersville Jeffersonville Irwinton Dublin Gray McRae Wrens Warrenton Gibson Sparta Milledgeville

Patient Information and Registration Record

Last Name:		First Name:		Middle Initial:
Street Address:			P.O. Box	
City, State, and Zip			County	
Home Phone:		Work Phone:	Cell Phone:	
Social Security Number:				
Date of Birth: / /				
Contact Preference: <input type="checkbox"/> Mail <input type="checkbox"/> Voicemail-Home <input type="checkbox"/> Voicemail-Cell <input type="checkbox"/> Text <input type="checkbox"/> Email:				
Employment Status: <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Student Full-time				
<input type="checkbox"/> Student Part-time <input type="checkbox"/> Not a Student				

Billing Information

Person Responsible for Bill:		
Relationship to Patient:		Social Security Number:
Responsible party's employer and address:		
Street Address		Home Phone:
City, State, and Zip		Work Phone: Other:

Insurance Information

Do you have insurance other than Medicare or Medicaid?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have prescription benefits with you insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Financial Assistance Information

We offer a sliding fee scale for qualified patients. Are you interested in applying for assistance?

Yes- Please give me an application

No- I am not interested in applying for any financial assistance. I understand I can apply at a later date.

(A separate application and verification of income is required for this service.)

Which category best describes your current yearly income? <\$10,000 \$10,000-14,999 \$15,000-19,999

\$20,000-29,999 \$30,000-49,999 \$50,000-79,999 over \$80,000 prefer not to answer

Emergency Contact Information

1) Person to contact in case of an Emergency:

Relationship to Patient:		
Home Phone:	Work Phone:	Other:

2) If unable to contact this person, please call:

Relationship to Patient:		
Home Phone:	Work Phone:	Other:

How were you referred to us: Self Friend or Family Member Health Provider Emergency Room Ad, Media or Outreach Other _____

Payment and Treatment Consent

Consent for Treatment: I hereby consent to any treatments, diagnostic tests or studies necessary by any physician or staff member of Community Health Care Systems, Inc. Release of information to third party: I hereby authorize Community Health Care Systems, Inc. to furnish information concerning my treatment, diagnosis, tests, and illness to third party payers for payment of fees incurred during treatment and diagnosis. I also understand that any portion that is not covered by insurance is my responsibility to pay. I understand that CHCS, Inc. may use any means deemed necessary to collect a debt. Payment is expected at time of service for all co-pays and deductibles.

Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices provided to me by Community Health Care Systems, Inc.

Rights and Responsibilities

My Rights and Responsibilities have been made available to me by Community Health Care Systems, Inc.

Signature of Patient/Representative:	Date:
Relationship if other than Patient:	
Pharmacy:	Consent for External RX check <input type="checkbox"/> Yes <input type="checkbox"/> No

HIPPA/RELEASE OF INFORMATION PER PATIENT'S ASSIGNMENT

Patient Name: _____ **Date of Birth:** _____

I, _____ (DOB) ___ / ___ / _____ have acknowledged/ received a written copy of the Community Health Care Systems, Inc (CHCS) Notice of Privacy Practices and I authorize any physician/ staff employee of CHCS to engage in any verbal or written communication to any/ all persons listed below regarding my medical history/care/ records/ appointments and/ or information pertaining to my person account/ billing history with CHCS.

NAME:	RELATIONSHIP:
_____	_____
_____	_____

VOICEMAIL/ ANSWERING MACHINE

I authorize any physician/ staff employee of CHCS to leave health information on a voicemail/ answering machine at the following numbers:

PHONE NUMBER:	LOCATION (Home, Cell, Work, etc.):
_____	_____
_____	_____

PATIENT UNDER AGE

If a patient is a minor (under age 18 years), please list any other person(s) over the age of 18 that is allowed to bring the minor to office visits and/ or labs. If the child is brought to an office visit by a person not listed below, written consent by parent/ guardian must be provided at date of visit.

NAME:	RELATIONSHIP:
_____	_____
_____	_____

I understand that this authorization may be revoked or modified at any time on submission of my written request or that of my representative.

_____	_____
Patient/Guardian Signature	Date

Community Health Care Systems, Inc.

In an effort to better serve all the patients in our communities we ask you to answer the following questions

Patient Additional Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Marital Status: Married Partnered Single Divorced Widowed Unknown Legally Separated

Language Preference English Spanish Other Translator Required: Yes

Veteran Status: Veteran Not a Veteran

Are you a migratory/agricultural worker? Yes No **Do you live in public housing?** Yes No **Are you homeless?** Yes No

Race: White or Caucasian Black or African American American Indian or Alaska Native Native Hawaiian or other Pacific Islander Other Race

Ethnicity: Hispanic Non-Hispanic

Who is your primary Care Giver? Self Parent Grandparent Sibling Spouse Life Partner Caregiver Ward of court/Guardian Unknown

Sexual Orientation is defined as to which gender(s) a person is physical y attracted: to the opposite gender (heterosexual), to the same gender (homosexual), or to both genders (bisexual).

Sexual Orientation- Do you think of yourself as: Lesbian, gay or homosexual Straight or heterosexual Bisexual Something else, please describe _____
 Don't know Decline to answer, please explain why _____

Gender Identity is defined as a person's identification as male or female, which may or may not correspond to the person's boy or their sex at birth (meaning what sex was originally listed on a person's birth certificate).

Gender Identity- What is your current gender identity? (Check all that apply)

Male Female Female-to-Male (FTM)/Transgender Male/Trans Man Male-to-Female (MTF)/Transgender Female/Trans Woman Genderqueer, neither exclusively male nor female
 Additional Gender Category/(or Other), please specify _____
 Decline to Answer, please explain why _____

Sex at Birth- What sex you were assigned at birth on your original birth certificate

Sex at Birth- What sex were you assigned at birth? Male Female Decline to Answer, please explain why _____

Please indicate your preferred provider: _____

Advance Directive

I have an Advance Directive Living Will Durable Power of Attorney for Health Care
 I do not have an Advance Directive and would like to obtain more information.

Signature of Patient/Representative: _____ **Date:** _____

Relationship if other than Patient: _____

Community Health Care Systems, Inc. - Patient History Questionnaire

Name: _____ **Date of Birth:** ____/____/____

Date Completing Form: ____/____/____ **Sex:** Male Female

Allergies: Have you ever had an allergic reaction to any of the following? Check or circle all that apply.

- Penicillin Codeine TB Shot Shrimp/Shell Fish Latex
 Sulfa Iodine Eggs Adhesive Tape Other: _____

If yes to allergy, what happens? _____

Past Medical History: Have **you** had any of the following? Check or circle all that apply.

- Seizures High Blood Pressure Heart Disease Pace Maker Thyroid Disorder Gout
 Cancer Hemorrhoids Kidney Disease Stomach Problems Anemia
 Diabetes Tuberculosis Tobacco Use Alcoholism Drug Use Glaucoma
 Asthma Liver Disease Depression/Anxiety Neurological Problems Bleeding Disorder Pain
 Arthritis Hepatitis Short of Breath Emphysema/Bronchitis Flu Shot
 Stroke Chest Pains Change in Bowels Blood Transfusion Change in weight Pneumonia shot
 Cough Joint pain Kidney Stones Skin Problems Sexual Transmitted Disease Other

Have you ever had any past hospitalizations or surgeries? Yes No If yes, please list: _____

Do you see other healthcare providers? Yes No If yes, please list: _____

Learning & Communication Needs: Check or circle any of the following needs, wants or beliefs that you would like to discuss or that you feel might affect your care. **Level of School Completed:** _____

- Cultural Beliefs Emotional Issues Hearing/Vision Problems Ability/ Desire/ Motivation to Learn
 Religious Beliefs Physical Limitations Financial Limitations Language Barriers
 Other: (Please describe) _____

Prefer to Learn: Seeing/Visual Hearing/Verbal Reading/Written Doing/Hands On

Family Medical History:

Family Member	Living?		Number of:	If Family Member is not living, then what was the cause of death?
	Yes	No		
Father				
Mother				
Brothers				
Sisters				
Children				

Has anyone in your **family** had any of the following? Check or circle all that apply.

Illness	Relation to You
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Heart attack / Angina	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Asthma / Respiratory Problems	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Stomach problems / Ulcers	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Drug Abuse / Alcoholism	
<input type="checkbox"/> Depression / Anxiety / Suicide	

Illness	Relation to You
<input type="checkbox"/> Anemia / Blood disorder	
<input type="checkbox"/> Kidney / Bladder Disorder	
<input type="checkbox"/> Glaucoma / Eye Disorder	
<input type="checkbox"/> Arthritis / Joint disease	
<input type="checkbox"/> Lung Disease / Tuberculosis	
<input type="checkbox"/> Sexual Disease / HIV	
<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Gout	
<input type="checkbox"/> Thyroid Disorder	
<input type="checkbox"/> Surgeries / Hospitalizations	

Patient/Guardian Signature: _____ **Date:** ____/____/____

COMMUNITY HEALTH CARE SYSTEMS, INC.

PATIENT RIGHTS AND RESPONSIBILITIES

You are a valued member of your health care team! As a patient or a patient's family member, you are not just an observer in your health care experience, but are an active team member. You have certain rights and responsibilities as a health care team member.

You have the RIGHT to:

- *Exercise these rights without regard to sex, race, creed, or cultural, economic, educational, religious background, or the source of payment for your care.
- *Considerate and respectful care that respects your personal values and beliefs.
- *Know the name of the physician who will be coordinating your care and the names of other physicians and other staff who will see you.
- *Receive information from the physician about the illness, course of treatment and prospects for recovery in terms that you can understand.
- *Receive as much information as you need about any planned treatment or procedure in order to give informed consent or to refuse a course of treatment.
- *Take part in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- *Full consideration of privacy concerning the medical care program. Occasionally, you may be seen by a student of the health sciences or a Center staff member may need to be present during your exam.
- *Confidential treatment of all communications and records pertaining to health status and care.
- *Reasonable responses to any reasonable requests made for service or access to care.
- *Be informed by the Center staff of the ongoing health care requirements following the visit.
- *Examine and receive an explanation of financial bill regardless of source of payment.
- *Participation in making care decisions throughout the care process when involved in investigational studies and clinical trials. You will not be enrolled in such programs without your knowledge and consent.
- *Have cultural, spiritual, psychological, and personal values respected as long as these practices do not harm others or interfere with care.
- *Expect appropriate assessment and management of pain.

You have the RESPONSIBILITY for:

- *Providing accurate and complete information concerning present complaints, past medical history, current medications, the presence of advanced directives and other information related to health status.
- *Making it known whether the course of treatment and the patient's role in the course of treatment is clearly understood.
- *Following the treatment plan established by the physician, including the instructions of members of the health care team related to the plan of care.
- *Keeping appointments and notifying the Center in advance if unable to keep an appointment.
- *Actions and the outcomes of those actions should you refuse treatment or not follow the plan of care.
- *Assuring that the financial obligations of care are fulfilled as promptly as possible.
- *Following Center policies and procedures affecting patient safety and conduct.
- *Being considerate of the rights of other patients and Center staff.
- *Being respectful of the property of self, others, and the Center.
- *Discussing pain relief options with the provider.
- *Complying with the pain management plan.