Frontier Community Health Clinic

Client Registration

The information in your medical Record is confidential and is protected under Colorado's General Laws. Your written consent will be required for release of information except in the case of a court order.

Legal Name: Last First Middle Initial Name Used

Legal Sex (Please check One)* ❑ Female ❑ Male

* Please be aware that the name and sex you have listed on your insurance card must be used on documents pertaining to insurance, billing and correspondence or your claim could be denied. If your preferred name and pronouns are different from these, please let us know.

Date of Birth: *Month Day Year* / /	**Social Security #**	

Home Phone # ( ) **Ok to leave a detailed message?** ❑ YES ❑ NO	**Day Phone #** ( ) **Ok to leave a detailed message?** ❑ YES ❑ NO ❑ TEXT	**Alternate Phone #** ( ) **Ok to leave a detailed message?** ❑ YES ❑ NO	**Best Number to Use** ❑ Home ❑ Day ❑ Alternate

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Mailing Address: **City** **State** **Zip**

Email Address:

Occupation: **Employer/School Name:**

Emergency Contact's Name: **Phone Number:** **Relationship to You:**

Primary Physician Name: **Primary Dentist Name:**

RESPONSIBLE PARTY INFORMATION (Any patient under 18 must have a responsible party)

☐ **Patient** (18 years or older) ☐ **Custodial Parent** ☐ **Guardian** (proof of legal status required for treatment)

LAST NAME	FIRST NAME	MI

PLACE OF EMPLOYMENT

STREET ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	SOCIAL SECURITY #	HOME PHONE

DENTAL INSURANCE

☐ **I currently have DENTAL insurance (See Below)**
☐ **I currently DO NOT have DENTAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Name of Insurance_____

Policy # AND Phone#_____

☐ I **currently have secondary DENTAL insurance (See Below)**

Name of Insurance_____

Policy # *AND* Phone#_____

MEDICAL INSURANCE (including Medicaid/Medicare

☐ **I currently have MEDICAL insurance (See Below)**
☐ **I currently DO NOT have MEDICAL insurance**
☐ **I would like to apply for the SLIDING-FEE SCALE**

Name of Insurance_____

Policy # AND Phone#_____

☐ I **currently have secondary MEDICAL insurance (See Below)**

Name of Insurance_____

Policy # *AND* Phone#_____

If you wish to have your medical/dental or billing information released to a family member, friend, or legal representative, you must sign this form. Signing this form will only give consent to release this information to the persons indicated below. This consent form will not allow FCHC to release any other information to these persons. You have the right to revoke this consent in writing.

I authorize/allow FCHC to release my medical/dental and/or billing information to the following individual(s):

Name	Relationship to Patient

I authorize the release of my Medical/Dental records **FROM** the following Establishments or Providers that I have seen in the past 3 years:

From:_____ & _____

Signature:_____Date_____

This information optional and is for demographic purposes only and will not affect your care.

1. What is your Gender Identity? ❑ Male ❑ Female ❑ Transgender Male/F to M ❑ Transgender Female/M to F ❑ Other ❑ Choose not to disclose	***2. Sexual Orientation?*** ❑ Lesbian, gay or homosexual ❑ Straight or heterosexual ❑ Bisexual ❑ Something else ❑ Don't know ❑ Refuse to provide	***3. Racial Group(s) (Check all that apply)*** ❑ African American/Black ❑ Asian ❑ Caucasian/White ❑ Native American/Alaskan Native/Intuit ❑ Pacific Islander	***4. Ethnicity?*** ❑ Hispanic/Latino/Latina ❑ NOT Hispanic/Latino/Latina ❑ Refuse to provide
5. Preferred Language? _____	***6. What is your Annual Income?*** ***$_____*** ❑ ***No Income*** ❑ ***Refuse to provide***	***7. How many people (including you) does your income support?*** ***#_____***	***8. Housing Status?*** ❑ NOT Homeless ❑ Homeless ***~If homeless mark below:*** ❑ Doubling up ❑ Homeless Shelter ❑ Street ❑ Public Housing ❑ Tenant Based Voucher
9. MIGRANT Agricultural Worker? ❑ Migrant ❑ Seasonal ❑ Not Applicable	***10. Veteran Status?*** ❑ Veteran ❑ Not a Veteran		

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: _____

		If "Yes", please describe on next page:
Are you under a physician's care now?	❑ YES ❑ NO	
Have you ever been hospitalized or had a major operation?	❑ YES ❑ NO	
Have you ever had a serious head or neck injury?	❑ YES ❑ NO	
Do you use marijuana for medical or recreational purposes?	❑ YES ❑ NO	
Do you use alcohol?	❑ YES ❑ NO	
Do you use any other illicit drugs?	❑ YES ❑ NO	
Are you on a special diet?	❑ YES ❑ NO	
Do you take supplements, such as vitamins, etc.?	❑ YES ❑ NO	
Artificial Heart Valve?	❑ YES ❑ NO	If yes, do you pre-medicate? ❑ YES ❑ NO
Artificial joint(s)?	❑ YES ❑ NO	If yes, do you pre-medicate? ❑ YES ❑ NO
Any Allergies?	❑ YES ❑ NO	If "Yes", please describe on next page:
Women Only – Are you… ❑ Pregnant/Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?		

Certain medical problems or medications may affect the treatments we provided. **Do you have, or have you had, any of the following?**

AIDS/HIV Positive	❑ Yes ❑ No	Dizziness	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Alzheimer's Disease	❑ Yes ❑ No	Frequent Cough	❑ Yes ❑ No	Pain in Jaw Joints	❑ Yes ❑ No
Anaphylaxis	❑ Yes ❑ No	Frequent Diarrhea	❑ Yes ❑ No	Parathyroid Disease	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Frequent Headaches	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Arthritis/Gout	❑ Yes ❑ No	Genital Herpes	❑ Yes ❑ No	Radiation Treatments	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Recent Weight Loss	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No	Renal Dialysis	❑ Yes ❑ No
Blood Transfusion	❑ Yes ❑ No	Heart Attack/Failure	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Breathing Problems	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Bruise Easily	❑ Yes ❑ No	Heart Pacemaker	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Heart Trouble	❑ Yes ❑ No	Shingles	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Sickle Cell Disease	❑ Yes ❑ No
Chest Pains	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Sinus Trouble	❑ Yes ❑ No
Cold Sore	❑ Yes ❑ No	Hepatitis A	❑ Yes ❑ No	Spina Bifida	❑ Yes ❑ No
Fever Blisters	❑ Yes ❑ No	Hepatitis B or C	❑ Yes ❑ No	Stomach Disease	❑ Yes ❑ No
Congenital Heart Disorder	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Intestinal Disease	❑ Yes ❑ No
Convulsions	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Steroids/Prednisone Meds	❑ Yes ❑ No	Hives or Rash	❑ Yes ❑ No	Swelling of Limbs	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Hypoglycemia	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Irregular Heartbeat	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Drug Addiction	❑ Yes ❑ No	Kidney Problems	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Easily Winded	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No	Tumors or Growths	❑ Yes ❑ No
Emphysema / COPD	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Epilepsy or Seizures	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Excessive Bleeding	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Yellow Jaundice	❑ Yes ❑ No
Excessive Thirst	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No		

Other Serious Disease not listed (please explain):

To the best of my knowledge, I accurately answered the questions on this form. I understand that providing incorrect information about the patient can be dangerous to the patient' health. I will inform the medical office of any changes in medical status.

Signature: _____Date: _____

If the patient is a minor, I am the child's (CHECK ONE) ❑ Mother ❑ Father ❑ Legal Guardian

Frontier Community Health Clinic

Medications & Other Information

Please list all medications or drugs (prescription, over the counter, etc.) and supplements (vitamins, minerals, herbs, etc.)

You can also use this page to provide additional information from the previous page.

Name	Dosage	How often do you take this?	Why do you take this?

Notes from previous page:

_____

_____

_____

_____

_____

_____

_____

Frontier Community Health Clinic – Consent for Treatment

Consent to Treatment
I hereby give my consent for treatment for myself, or the named patient (of whom I am the parent or legal guardian who has the right to consent to treatment for the named patient) to the Frontier Community Health Clinic (FCHC).

Consent to Release of Health Information, including Health/Treatment Records for Treatment, Payment and Health Care Operations
I consent to the use within FCHC and the disclosure to persons or organizations outside of FCHC of my (or of the named patient for whom I am the parent or legal guardian) medical, dental, behavioral health and other treatment and health records and information (such health records and information are referred to in this Consent as my "Health Information") by FCHC for the following purposes:

A. Use of Health Information By or For FCHC for Treatment and for Health Care Operations:
- Providing treatment by FCHC staff;
- Conducting health care operations of FCHC including, for example, financial or quality assurance audits and training.

B. Disclosure of Health Information to Persons Outside FCHC for Treatment Purposes and for Payment
- Providing Health Information to other health providers or agencies who may be involved in my care;
- Obtaining payment for health care bills, including sending such Health Information as is needed to secure payment for FCHC services to the insurance company, worker's compensation company or agency that pays for my health services, as identified in my DCHC Registration form or other updated insurance information on file with FCHC.

I have read the Consent for Treatment and Consent to Release of Health Information and I understand and consent to its content and that I have the right to revoke this Consent at any time.

Signature:_____Date_____

Financial Responsibility
You are responsible for the balances not covered by insurance or third party payers. FCHC accepts assignment on Medicare and Medicaid claims. If you qualify, a sliding scale discount may be applied to the unpaid balance or any "out of pocket" expenses. Discounts are available based on household size and household income.

FCHC does NOT operate a "free clinic". Regardless of insurance coverage or financial category, no patient will be refused services because of an inability to pay. You must agree to demonstrate a willingness to pay and UNwillingness to pay may result in dismissal as a patient. If you fail to provide income verification or proof of insurance, you will not be eligible to participate in a sliding discount and will be responsible for 100% of the charges or services rendered by FCHC. You agree to pay your fees and/or insurance co-payment and required deductible at the time of service. Any balance on your account after 120 days may be sent to a collection agent.

I hereby acknowledge that I have been offered a copy of FCHC's Payment Expectations document and understand and agree to adhere to these expectations and have asked to apply for the Sliding Fee Discount if I chose to.

Signature:_____Date_____