SAMUEL U. RODGERS
HEALTH CENTER

☐ Samuel U. Rodgers Health Center Downtown Campus
☐ Samuel U. Rodgers Health Center Northland Family Medicine & WIC Services
☐ Samuel U. Rodgers Health Center Sheffield Place
☐ Samuel U. Rodgers Health Center J.A. Rogers Family Dental
☐ Samuel U. Rodgers Health Center Clay County Family Medicine
☐ Samuel U. Rodgers Health Center Independence Family Dental
☐ Samuel U. Rodgers South
☐ Samuel U. Rodgers Health Center Lafayette Family Medicine, Dental & WIC Services

PATIENT DEMOGRAPHIC INFORMATION

This form is to be completed on every patient and placed in Medical Records Chart

Date:_____/_____/_____

Print Patient Name:_____ Date of Birth:_____ Gender (Circle One) M / F

Address:_____ Apt#____ City:_____ State:____ Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____

Email address:_____

Can we contact you by email and cell phone or text? ___ Yes ___ No

Parent/Legal Guardian: (print)_____ Relationship to patient:_____ Phone (if different) (___)_____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widow(er)

Race: ___ American Indian/Alaskan ___ Asian ___ Black/African American ___ Hispanic/Latino Black ___Hispanic/Latino other ___ Hispanic/Latino White ___ Native Hawaiian ___ Refuse to Report ___ White ___ Refuse to Report

United States Veteran: ___ Yes ___ No Smoke: ___ Yes ___ No

Insurance Information

Do you have insurance? ___ Yes ___ No

Medicaid/Medicare #: _____ Plan Name: _____

Private Insurance Name: _____ Policy #: _____

Group #: _____ Policy Holders Name: _____

Policy Holders Address:_____ Policy Holders Date of Birth:_____

Patient's Doctor/Clinic: _____

Notify In Case of Emergency

Name: (Print) _____ Relationship: _____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Can we contact this person by email and cell phone or text? ___ Yes ___ No

Total Household Income Information

Total Household Size: _____ Total Household Income: $_____

__ Hourly __ Weekly __ Biweekly __ Monthly __ Semi Monthly __ Hours Worked Wkly_____

Print Name: _____ Signature:_____
Responsible Party Responsible Party

Revised 6/24/11

SAMUEL U. RODGERS
HEALTH CENTER

Quality Care • Universal Compassion

GENERAL CONSENT FORM

The undersigned patient and/or responsible person having registered at Samuel U. Rodgers Health Center for the purposes of obtaining health services, do hereby, voluntarily consent such diagnostic and treatment services, as might be provided by or at the direction of a physician, dentist, or other health care professional or other qualified member of the staff of the Samuel U. Rodgers Health Center to me according to his/her judgment.

I recognize that I have the right to refuse any specific diagnostic or treatment service without jeopardizing my right to receive health services at the Health Center.

I recognize that I will be asked to sign a specific consent for surgical and other special procedures including general and/or extensive local anesthesia. I am aware that health services are not based on an exact science and I acknowledge that no guarantees have been made to me as to the results of any treatment services.

I hereby authorize Samuel U. Rodgers Health Center to furnish such information from my medical record pertaining to any and all treatment as requested by either health insurance plans or companies if applicable to my case. I give my consent to release my information to Pharmaceutical Companies for auditing purposes in the Bulk Replacement Patient Assistance Programs.

I hereby authorize payment of health insurance benefits recorded on the registration form to be paid directly to Samuel U. Rodgers Health Center for services provided.

I understand that the charges for which I am responsible will reflect the balance due after credit for all appropriate discounts and all collections received by Samuel U. Rodgers Health Center from health insurance benefits.

I agree to pay these charges on the day that the services are provided or within 10 days of receipt of the statement or by some other payment arrangement agreed to by the billing/collections department at Samuel U. Rodgers Health Center.

I hereby certify that I have been offered a copy of the Samuel U. Rodgers Health Center's Notice of Privacy Practices.

I hereby certify that I have been offered a copy of Samuel U. Rodgers Health Center's Appointment Cancellation Policy. Patients that choose not to keep scheduled appointments and who fail to keep their appointment three (3) times within a six (6) month period will only be seen on a same-day basis in the future. Canceling with short notice (less than 24 hours), showing up late, or not showing up at all is very disruptive for our schedule and unfair to our other patients who value prompt treatment.

I hereby certify that I have not knowingly withheld any information or income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge. If I have knowingly provided any false information I may be prohibited from receiving services at Samuel U. Rodgers Health Center in the future. I certify I will contact the facility in the event I have an insurance and/or income change.

This form has been fully explained to me and I certify that I understand its contents.

Signature _____ Date _____

Witness _____ Date _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration and its intermediaries or carriers as information is needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payment of medical insurance benefits to Samuel U. Rodgers Health Center.

Signature _____ Date _____

Witness _____ Certification Date _____

Revised 06/10/2013

SAMUEL U. RODGERS
HEALTH CENTER

SAMUEL U. RODGERS HEALTH CENTER
PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

We welcome you as a patient to Samuel U. Rodgers Health Center. It is the policy of the Health Center to inform and notify patients of their rights and responsibilities regarding our health care services.

With your cooperation, we want to help you enjoy the best health possible.

Patient Rights: (Our Responsibility to You)

1. You have the right to refuse treatment.
2. You have the right to be fully informed of all rules and regulations governing center activities.
3. You have the right to be informed of all available services at the Health Center.
4. You have the right to an explanation about charges for services including third-party payment.
5. You are entitled to information concerning your medical condition and plan for treatment.
6. You may refuse to participate in any experimental research.
7. You have the right to submit complaints and recommend policy changes to center staff and governing body.
8. You will be informed of the procedure to follow in case of emergency when the Health Center is closed.
9. Your records are confidential. You have the right to refuse the release of your medical information except as required by third-party payment contracts.
10. At all times you are to be treated with respect, consideration and dignity, including privacy in treatment and personal needs.

Patient Responsibilities: (Your Responsibilities as a Patient)

1. You are responsible for keeping your appointments, or notifying the Health Center in advance when unable to do so.
2. You are obligated to give truthful information.
3. You are expected to abide by all rules and regulations with regard to patient conduct to responsibilities.
4. You are responsible for taking medications and treatments as prescribed by your doctor.
5. You are responsible for paying fees and co-pays according to insurance and sliding fee scales.

Confirmation of Receiving Patient Bill of Rights

I have been given the opportunity to have a copy of the Samuel U. Rodgers Health Centers' Patient Bill of Rights. After reading this document, I have had a chance to ask questions and believe I understand what the Patient Bill of Rights means, what I might expect from this health care facility and what is expected of me and my family members as registered patients of the Health Center.

Signature:_____ Date:_____

Interviewers Initials:_____ Date:_____

Interpreter's Signature:_____ Date:_____

SAMUEL U. RODGERS
HEALTH CENTER

About the
Notice of Privacy Practices

The Health Center is committed to protecting patients' personal health information in compliance with Federal law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint, if you believe your privacy rights have been violated.
- The person to contact for further information about our privacy practices.

We are required by law to offer all patients a copy of our Notice of Privacy Practices.

Patient Acknowledgment of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature **Date**

_____

Signature of Parent or Patient's Representative (if applicable) **Date**

_____

Description of Legal Authority to Act on Behalf of Patient

_____

Interpreter signature **Date**

SAMUEL U. RODGERS
HEALTH CENTER

SLIDING FEE FORM

Name:
Address:
City, State: County:
Zip Code:
Home/Cell:
email:
Date of Birth:
Chart Number:

Sliding Fee Eligibility Form

It may be necessary to ask some personal questions in order to determine eligibility for a discount on medical, dental or pharmaceutical charges. This information is private and confidential and will be kept on file in the Center. Income verification in determined once a year. Yearly income tax returns with a copy of W-2s, three most recent pay check stubs or copies of Social Security or other checks should be sufficient proof of income. Annual gross household income statements will be used to calculate discount and level of payment.

Todays Date: _____ Number of people living in your home? _____

What is your marital status? ___ Married ___ Widow(er) ___ Single ___ Divorced ___ Separated

Give names, addresses and or phone numbers of the employers for you, your significant other, children, other household members.

Name:	Name:
Address:	Address:
City, State:	City, State:
Phone Number:	Phone Number:

	You		Spouse	
Notify in case of emergency:				
Address:				
Phone:				

Do you have any income from any of the following sources, and if so, how much?

Sources	You	Your Spouse	Your Children	Other Person	Total Sources
Social Security					
Public Assistance					
Retirement Pension					
Rental Income					
Interest Income					
Child Support, Alimony					
Other (Specify)					

Do you have any type of insurance? ___ Yes, List below ___ No

Amount of Household Income?

You	Your Spouse	Your Children	Other Person	Total Household Income

I declare the above information is true and have given Samuel U. Rodgers Health Center permission to investigate any information in this application. I understand this information will be kept confidential. Also I understand that should my income change, I am required to notify the care representative on my next visit to the center with documented proof of the change.

Patient Signature:	Date:	Clinic Purpose Only:
Employee Signature:	Date:	Income Code:

SAMUEL U. RODGERS
HEALTH CENTER

SLIDING FEE FORM

List Dependent Children under 18 years of age that live with you.

	Name	DOB	Relationship	Proof Document
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

List Other Household Members 18 years of age and older that live with you.

	Name	DOB	Relationship	Proof Document
1				
2				
3				
4				
5				

NAME:_____
PATIENT #:_____
D.O.B. :_____

SAMUEL U. RODGERS COMMUNITY HEALTH CENTER
DENTAL PATIENT -- MEDICAL HISTORY FORM

Physician _____ Office Phone_____ Date of last Exam_____

	YES	NO
Are you under any medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If so, please explain_____		
Are you taking any medication(s) including non-prescription medicine(s)?	☐	☐
If yes, what medication(s) are you taking?		
Have you ever taken Phen-Fen / Redux?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO THE FOLLOWING:

	YES	NO
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin / other antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Metals (nickel, mercury, etc)	☐	☐
Latex Rubber	☐	☐
Other_____	☐	☐

WOMEN ONLY

a) Are you pregnant / think you may be?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Chest Pains	☐	☐
Heart Attack	☐	☐
Cardiac Pacemaker	☐	☐
Easily Winded	☐	☐
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐
Angina	☐	☐
Low Blood Pressure	☐	☐
Glaucoma	☐	☐
Miral Valve Prolapse	☐	☐
Respiratory Problems	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Hay Fever / Allergies	☐	☐
Cancer	☐	☐
Leukemia	☐	☐
Radiation Therapy	☐	☐
Epilepsy / Convulsions	☐	☐
Fainting / Seizures	☐	☐
Frequently Tired	☐	☐
Recent Weight Loss	☐	☐
Anemia	☐	☐
Mental Illness	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Hepatitis	☐	☐
Thyroid Problem	☐	☐
Stomach troubles	☐	☐
Sexually transmitted disease	☐	☐
AIDS or HIV	☐	☐
Ulcer	☐	☐
Joint Replacement or Implant	☐	☐

YES	NO	
☐	☐	Do your gums bleed when you brush?
☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?
☐	☐	Do you wear removable dental appliances?
☐	☐	Do you clench or grind your teeth
☐	☐	Do you chew ice or other objects?

YES	NO	
☐	☐	Have you ever had Orthodontic (braces) treatment?
☐	☐	Do you have headaches, earaches, or neck pain?
☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	Do you bite your cheeks?
☐	☐	Do you suck you finger or thumb?

_____Cigarettes – How many packs?_____
_____Cigars – How many?_____
_____Chewing Tobacco – How much?_____
_____Snuff – How mach?_____

SIGNATURE(Patient or Guardian)_____ DATE:_____
REVIEWED BY DENTIST:_____ DATE:_____

Rev'd 4/2006