# CHS Healthcare / Children's Health Network

**Date / Fecha ________________**

## Patient Information / Información del Paciente

| Last / Apellido | First / Nombre | Middle / Segundo Nombre |
|---|---|---|
| | | |

| Address / Dirección | City / Ciudad | State / Estado | Zip Code / Codigo Postal |
|---|---|---|---|
| Mailing Address / Dirección de correo | City / Ciudad | State / Estado | Zip Code / Codigo Postal |

| Home Phone / Telefono | Cell Phone / Celular | Other Phone / Otro Telefono |
|---|---|---|
| | | |

| Sex / Sexo (please circle /por favor marcar ) | M Masculino | F Femenino | DOB/ Fecha de Nacimiento ______/_______/______ | Social Security # /Numero de Seguro Social ______-______-________ |
|---|---|---|---|---|

**Marital Status / Estado Civil**: Married/ Casado ☐ Single/Soltero ☐ Other / Otro ☐

**Family Size / Cuantos miembros en la familia?**

**Race / Grupo Etnico O Raza**: Black/Negro ☐ White/Blanco ☐ Hispanic/Hispano ☐ Other/Otro ☐

**Residency /Su Estadia**: Seasonal/Temporal ☐ Migrant/Migratoria ☐ Other/Otro ☐

**Primary language Spoken by Patient /Cual es al Primer Idioma del Paceinte**: English / Ingles ☐ Spanish / Español ☐ Creole/Creol ☐ Indian Dialect/Indio del dialecto ☐ Other/Otra ☐

**Employment Status/Empleo** (please circle/ por favor marcar): Employed / Empleado  Part Time Student / Estudia Med./Tiempo  Full Time Student / Estudia Tiempo Completo  Other / Otro: _______________

| Employer / Empleador | Work Phone # / Telefono del trabajo |
|---|---|
| | |

| Employer Address / Dirección de Empleador | City / Ciudad | State / Estado | Zip Code / Codigo Postal |
|---|---|---|---|
| | | | |

**Are you, the patient, a veteran of a branch of military service? No___________________ Yes____________ If yes, which branch?_____________________**
**Es el paciente veterano de guerra o de alguna rama del servicio militar? No_____________ Si______________ Si su respuesta fue si, especifique que rama es _________________**

## Parent Information (if patient is a minor) / Información de los Padres (si el paciente es un menor)

| Mother's Name / Nombre de la Madre | DOB / Fecha de Nacimiento ______/_______/______ | Social Security # /Numero de Seguro Social ______-______-________ | Telephone # / Telefono # |
|---|---|---|---|

| Employer / Empleador | Work Phone # / Numero Telefonico del Trabajo |
|---|---|

| Employer Address / Dirección de Empleador | City / Ciudad | State / Estado | Zip Code / Codigo Postal |
|---|---|---|---|

| Father's Name / Nombre de la Padre | DOB / Fecha de Nacimiento ______/_______/______ | Social Security # / Numero del Seguro Social ______-______-________ | Telephone # / Telefono # |
|---|---|---|---|

| Employer / Empleador | Work Phone # / Numero Telefonico del Trabajo (empleo) |
|---|---|

| Employer Address / Dirección de Empleador | City / Ciudad | State / Estado | Zip Code / Codigo Postal |
|---|---|---|---|

## Insurance Information ("Policy Holder" is the one responsible for the ins. premium. E.G. self, parent, spouse)

| Policy Holder Name/ Name on Ins. Card / Nombre del Asegurado (como aparece en la tarjeta) | Sex / Sexo F / M | DOB / Fecha de Nacimiento ______/_______/______ |
|---|---|---|

| Insurance Plan Name / Nombre de Plan de Seguro | Plan # / Numero del Plan de Seguro |
|---|---|

| Insured ID # / Núm. de Identificación# (como aparece en la tarjeta) | Ins. Plan Address / Dirección (incluya ciudad, estado, y codigo postal) |
|---|---|

## Emergency Contact (Other than household member) / Contacto de Emergencia (persona que no pertenezca al grupo familiar)

| Name / Nombre | Address / Dirección |
|---|---|

| Phone # / Telefono | Relationship to Patient / Relación con el Paciente |
|---|---|

________________________________
Patient ID

# PATIENT REGISTRATION

________________________________

# CHS Healthcare

(Collier Health Services, Inc.)

Method of Payment (Check all that apply)

☐ **Self-Pay** ☐ **Insurance** ☐ **Medicaid** ☐ **Medicare** ☐ **Other** (please specify: ________________________)

☐ I wish to be considered for sliding fee scale. I have no Health/Dental Insurance coverage of any kind or my Health/Dental Insurance does not recognize CHS HEALTHCARE as a participating provider. I shall authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. In the event I am able to secure Health/Dental insurance coverage, I shall authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I will authorize payment of medical/dental benefits to CHS HEALTHCARE, for any services provided while a patient at CHS HEALTHCARE.

☐ I am currently covered by Health/Dental Insurance. I understand that if I am no longer covered by Health/Dental Insurance I may be considered for sliding fee scale. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

☐ I am currently covered by Medicaid. I understand that if I am no longer considered Medicaid eligible I may apply for sliding fee scale if I have no other Health/Dental Insurance. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

☐ I am currently on Medicare. If I currently do not have secondary coverage to Medicare I wish to be considered for sliding fee scale as a secondary. I authorize CHS HEALTHCARE to verify my income with my employer. I understand that written proof of income is required. I authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

☐ I **do not wish** to be considered for the sliding fee scale. In the event I am able to secure Health/Dental insurance coverage, I shall authorize the release of any medical/dental or other information necessary in order for CHS HEALTHCARE to process any insurance claims as a result of treatment. I will authorize payment of medical/dental benefits to CHS HEALTHCARE for any services provided while a patient at CHS HEALTHCARE.

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I, ______________________________________________, the guarantor, agree to be personally and fully responsible for the payment of any and all medical services, not covered by a federal, state or commercial benefit program, that are provided by CHS HEALTHCARE (Collier Health Services, Inc.).

I understand that I am personally and fully responsible for the payment of all applicable co-payments and deductible or, if applicable, the payment of the appropriate sliding fee. I understand that all applicable payments are due at the time of services.

I understand that in the event that I am unable to pay at the time of service or in the event of an outstanding balance, I will be required to speak to a financial counselor prior to services being rendered. I further understand that in order to remain a patient(s) in good standing, I may be required to sign a payment agreement.

Interpreted into: ________________________________By: __________________________________

_____________________________________________________________________________________

Signature of Patient/ Guarantor Date Signature of Witness Date

Patient ID Label

# PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

## CHS HEALTHCARE/CHILDREN'S HEALTH NETWORK

I, the undersigned parent or guardian of ___________________________________, hereby authorize CHS Healthcare (Collier Health Services Inc.), the Children's Health Network, its facilities or treatment centers, its affiliated physicians, dentists, surgeons, and other medical personnel in charge of my care, to administer examinations and treatments, as may be deemed medically necessary in the exercise of their professional judgment.

____________________________________ ___________

Signature of Parent or Legal Guardian Date

### CONSIENTA PARA el TRATAMIENTO DE UN MENOR

Yo, el padre o el guardián abajofirmantes de _______________________________, por la presente autorizo CHS Healthcare, Children's Health Network, sus centros de facilidades o tratamiento, sus médicos afiliados, los dentistas, los cirujanos, y otro personal médico a cargo de mi cuidado, para administrar exámenes y tratamientos, como se puede creer médicamente necesario en el ejercicio de su juicio profesional.

____________________________________ ___________

Firma del Padre el guardian Fecha

### CONSENTIR POUR LE TRAITEMENT D'UN MINEUR

Mwen, antan ke paran ou gadyen sonsignyen, ______________________________, otorize CHS Healthcare, the Children's Health Network, fasilite ou sant de sante, afilye ak fizisyan, dantis, chirijyen, e tout pesonel medical ki responsab de swen mwen, pou administer ezamen e tretman, ki kapab konsidere medikalman nesese nan exzesis jijman pesonel.

____________________________________ ___________

Syiate Paran Dat

___________________________________

Patient ID

# CONSENT FOR TREATMENT OF A MINOR

___________________________________

## CHS/UF Pediatric Dental

NCEF Pediatric Dental Center

Patient Name: ______________________________ Date of Birth: ____________

| Child's Name | Nickname | Date of Birth | Date |
|---|---|---|---|
| Mother | Father | Guardian | |
| Mother's Occupation | Employer | Phone | |
| Father's Occupation | Employer | Phone | |
| Payment Method: Private Pay ( ) | Insurance ( ) | Medicaid ( ) | CMS ( ) |

## HEALTH HISTORY

Primary Care Physician's Name: ______________________________ City: ____________

Date of Last Physical Exam: ______________________________ Phone # ____________

Is the child taking any medications now? ( ) Yes ( ) No

| List Medications | Treatment For: | Date Started: |
|---|---|---|
| | | |
| | | |
| | | |

Has this child ever been hospitalized? ( ) Yes ( ) No

Why? ______________________________ When? ____________

Has this child ever been treated in an emergency room? ( ) Yes ( ) No

Why? ______________________________ When? ____________

Does this child have or has this child every had any of the following conditions:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ( ) | ( ) | Allergies ____________ | ( ) | ( ) | Hypertension |
| ( ) | ( ) | Drug Reactions ____________ | ( ) | ( ) | Diabetes |
| ( ) | ( ) | Latex Sensitivity | ( ) | ( ) | Cancer |
| ( ) | ( ) | Asthma | ( ) | ( ) | Birth Defects |
| ( ) | ( ) | Breathing Problems | ( ) | ( ) | Cleft Lip/Palate |
| ( ) | ( ) | Premature/Low Birth Weight | ( ) | ( ) | Cerebral Palsy |
| ( ) | ( ) | Anemia | ( ) | ( ) | Delayed Speech Development |
| ( ) | ( ) | Bleeding Problems | ( ) | ( ) | Developmentally Delayed |
| ( ) | ( ) | Sickle Cell Anemia | ( ) | ( ) | Seizures |
| ( ) | ( ) | Heart Condition/Murmur | ( ) | ( ) | Fainting Spells |
| ( ) | ( ) | Rheumatic Fever | ( ) | ( ) | Hyperactivity/ADHD |
| ( ) | ( ) | TB HIV Hepatitis | ( ) | ( ) | Psychiatric/Emotional Problems |
| ( ) | ( ) | Kidney Disease | ( ) | ( ) | Vision Problems |
| ( ) | ( ) | Liver Disease | ( ) | ( ) | Hearing Loss/Impairment |
| ( ) | ( ) | Jaundice | ( ) | ( ) | Other: ____________ |

**For Office Use Only:**

Medical Summary Precautions ______________________________

______________________________

______________________________Reviewed By: ____________

**Medical History Updated:**

| Date | No Change | Change(s) | Signature |
|---|---|---|---|
| ________ | ( ) | ____________ | ____________ |
| ________ | ( ) | ____________ | ____________ |
| ________ | ( ) | ____________ | ____________ |
| ________ | ( ) | ____________ | ____________ |

# HEALTH/DENTAL HISTORY (CHILD)

## CHS/UF Pediatric Dental

NCEF Pediatric Dental Center

## Dental History

Why is the child here today (What is your main dental concern?) ____________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Previous dentist's name: ___________________________________________ City: ____________________________________
Date of Last dental visit: ___________________________________________ Date of Last dental x-rays: __________________

| Yes | No | Does this child have any of the following? |
|---|---|---|
| ( ) | ( ) | Toothache? When? ________________________________________ |
| ( ) | ( ) | Accident/Injury to Teeth? When? _______________________________ |
| | | How? ______________________________________________ |
| ( ) | ( ) | Discolored/Stained teeth? |
| ( ) | ( ) | Bleeding gums? |
| ( ) | ( ) | Cold sores/canker sores (mouth sores)? |
| ( ) | ( ) | Tooth grinding/clenching? |
| ( ) | ( ) | Snoring/Mouth breathing? |
| ( ) | ( ) | Crowded or spaced teeth? |
| ( ) | ( ) | Pacifier/finger/thumb habit? |
| ( ) | ( ) | Sleeping with baby bottle/demand breastfeeding? |

## Oral Disease Prevention

| Yes | No | Does this child : |
|---|---|---|
| ( ) | ( ) | Brush his/her teeth |
| | | ( ) alone? ( ) supervised? ( ) assisted |
| ( ) | ( ) | Use fluoride toothpaste? |
| ( ) | ( ) | Use dental floss? |
| ( ) | ( ) | Frequently eat sweets and/or drink juices or soda? |

## Behavior Profile

How do you think this child has reacted to past medical or dental procedures?
( ) very good ( ) moderately good ( ) moderately poor ( ) very poor

How do you expect this child to react in the dental chair?
( ) very good ( ) moderately good ( ) moderately poor ( ) very poor

Does this child think there is anything wrong with his/her teeth?
( ) Yes ( ) No

What is (are) the child's interests and hobbies? ______________________________________________________________

Whom may we thank for referring you to our office? ___________________________________________________________

X_______________________________________________________ Relationship to this child? ______________________

Are you permitted by law (by right as a natural parent, legal adoption, or court order) to provide consent for the dental treatment of this child of this child? ( ) Yes ( ) No

# CHS HEALTHCARE/CHILDREN'S HEALTH NETWORK

**The Children's Health Network wishes to provide appropriate patient/ parent education to its clients.**
**Es el deseo de Children's Health Network proporcionar educacion adecuada para sus paciente/padres.**

**Please assist us by completing the following questionnaire.**
**Por favor colabore con nosotros completando el sigiuiente questionario.**

1. What language do you speak? ☐ English ☐ Spanish ☐ Creole ☐ Other: ________________
   Cual idioma habla usted? ☐ Ingles ☐ Espanol ☐ Creole ☐ Otro: ________________

2. What language do you read? ☐ English ☐ Spanish ☐ Creole ☐ Other: ________________
   Cual idioma lee usted? ☐ Ingles ☐ Espanol ☐ Creole ☐ Otro: ________________

3. What is your preferred teaching method? ☐ Verbal ☐ Written ☐ Demonstration
   Cual es su metodo de aprendizaje preferido? ☐ Oral ☐ Escrito ☐ Demostracion

4. Describe any learning impairments you may have (Vision, hearing, speech, emotional):
   Por favor describa si tiene algun problema que limite su proceso aprendizaje? (Vision, auditivo, oral, emocional):
   ________________________________________________
   ________________________________________________

5. Do you have any religious or cultural practices, which affect learning? ☐ Yes ☐ No
   Alguna practica cultural o religiosa pudiera interferir en su proceso de aprendizaje? ☐ Si ☐ No

   If yes, please describe: ________________________________
   Si contesto afirmativamente, por favor, explique:
   ________________________________________________
   ________________________________________________
   ________________________________________________

________________________ ________________
Signature Date

________________________
Printed Name

________________________
Relation to Patient

**FOR OFFICE USE ONLY**.

Ability to Learn: ☐ Good ☐ Fair ☐ Poor
Desire to Learn: ☐ Good ☐ Fair ☐ Poor

Initials of Nurse: _________ Date ______________

________________________
Patient ID

# PATIENT/ PARENT EDUCATION

________________________

**CHS Healthcare**

I, ____________________________________________________________, hereby acknowledge that I have received a copy of CHS's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by CHS and states my rights with respect to my medical information. I understand CHS has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event CHS revises its information practices, a revised Notice will be posted at CHS Healthcare and that I may obtain a current Notice of Privacy Practices upon request.

Interpreted in: __________________________________________

By: ___________________________________________________ Date ___________________

_______________________________________________________ ___________________

Signature of Patient/ Guardian/ Representative Date Signed

_______________________________________________________

If Guardian/ Representative, state Relationship to Patient

_______________________________________________________ ___________________

Signature of Witness Date Signed

_____________________________________________

Patient ID

_____________________________________________

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES