



# CHS Healthcare/Children's Health Network

Date \_\_\_\_\_

Patient Information				
Last		First		Middle
Home Address		City		State Zip
Mailing Address		City		State Zip
Home Phone		Cell Phone		Other Phone
Sex (please circle) M F	DOB		Social Security #	
Marital Status (please circle) Married Single Other		Family Size		Race (please circle) (B) Black (W) White (H) Hispanic (O) Other
Residency (please circle) Seasonal Migrant Permanent		Primary Language Spoken by Patient (please circle) (C) Creole (E) English (G) Indian Dialect (S) Spanish (O) Other		
Employment Status (please circle) Employed Part Time Student Full Time Student Other:				
Employer			Work Phone #	
Work Address		City		State Zip

Parent Information (if patient is a minor)			
Name		DOB	Social Security # Phone
Mother			
Employer		Work Phone #	
Work Address		City	State Zip
Name		DOB	Social Security # Phone
Father			
Employer		Work Phone #	
Work Address		City	State Zip

Insurance Information ("Policy Holder" is the one responsible for the insurance premium, e.g., self, parent, spouse.)				
Policy Holder Name/Name on Ins. Card			Gender: F / M	DOB:
Insurance Plan Name			Plan #	
Insured ID #	Ins. Plan Address	City	State	Zip

Emergency Contact (Other than household member)				
Name		Address	City	State Zip
Phone #		Relationship to Patient		

\_\_\_\_\_  
Patient ID

## PATIENT REGISTRATION



# CHS Healthcare

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- Have you (parent/ guardian) or the patient had any of the following problems?  Yes  No
1. Active Tuberculosis
  2. Cough greater than 3 weeks
  3. Cough that produces blood
  4. Been exposed to anyone with tuberculosis
- If you answered yes to any of the three items above, please stop and return form to receptionist.**

## MEDICAL/ DENTAL INFORMATION

1.  Yes  No Is the child allergic to any medications/ food/ materials?  
If yes, please explain: \_\_\_\_\_
2.  Yes  No Is the child taking any medications (including over the counter, herbal, birth control) at this time?  
If yes, please explain: \_\_\_\_\_
3.  Yes  No Is the child currently being treated for any illnesses?  
If yes, please explain: \_\_\_\_\_
4.  Yes  No Has the child ever had a serious illness/ been hospitalized?  
If yes, when: \_\_\_\_\_ Please describe: \_\_\_\_\_
5.  Yes  No Has the child ever had a blood transfusion?
6.  Yes  No Is the child physically, mentally, or emotionally impaired?
7.  Yes  No Is this the child's first visit to the dentist? If not, what was the date of last visit: \_\_\_\_\_
8.  Yes  No Are the child's teeth brushed daily? How many times? \_\_\_\_\_
9.  Yes  No Is fluoride toothpaste used?
10.  Yes  No Has the child had any injuries to mouth, head, or teeth?
11.  Yes  No Does the child suck thumb, finger, pacifier?
12.  Yes  No Had the child had any orthodontic treatment/ consultations?
13. What is the child's approximate weight? \_\_\_\_\_

### Have you had any history of, difficulty with, or diagnosis of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Heart murmur      | <input type="checkbox"/> Cerebral Palsy    | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> Rheumatic fever  |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart             | <input type="checkbox"/> Sickle cell      |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Drug use          | <input type="checkbox"/> HIV/ AIDS         | <input type="checkbox"/> Tobacco use      |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Epilepsy/ Seizure | <input type="checkbox"/> Kidneys           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Latex allergy     | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bone/ Joint       | <input type="checkbox"/> Growth problem    | <input type="checkbox"/> Liver             | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hearing           | <input type="checkbox"/> Pregnancy (teens) |   |

Is the child currently experiencing dental pain/ discomfort?  Yes  No

**Note:** Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/ her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient ID

## HEALTH/ DENTAL HISTORY (CHILD)



**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 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