NORTH COUNTRY COMMUNITY HEALTH CENTER, INC.
REGISTRATION FORM

MR#_____

I. Patient Information

Last Name: _____ First Name: _____ MI: _____

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

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

Phone: _____ *Please circle one:* Home/Work/Cell/Message _____ *Please circle one:* Home/Work/Cell/Message

Date of Birth: _____ Sex: (*Circle one*) Male Female Social Security Number: _____

Marital Status: (*Circle one*) Single Married Student Status: (*Circle one*) Full-Time Part-Time Not a Student

Employer Name : _____ Phone: _____
(*If patient is a child, please list responsible party's employer information.*)

Emergency Contact Name and Address: _____

_____ Phone: _____

Guarantor name, date of birth, and social security #: _____

_____ Phone: _____

For Statistical and/or Discount Program Purposes:

Income: (***Gross*** *household income*) $ _____ (*Circle One*) Weekly Biweekly Monthly Annually

Race: (*Circle one*) [A]sian [B]lack [H]ispanic [I] Native American [P]acific Islander [W]hite [O]ther

How did you hear about us? _____

II. Insurance Information

If you have medical and/or dental insurance, please provide a copy of your insurance card and fill out the following:

Primary Insurance:

Insurance Company: _____ Insurance ID: _____ Group: _____

Office Visit Co-Pay: $ _____ ***I understand that my co-pay is due at the time of service.*** _____ ***Initials***

If patient is not insured party- please complete the following:

Insured Party Name: _____ Social Security: _____

Insured Party DOB: _____ Patient Relationship to Insured Party: _____

Secondary Insurance:

Insurance Company: _____ Insurance ID: _____ Group: _____

Office Visit Co-Pay: $ _____ ***I understand that my co-pay is due at the time of service.*** _____ ***Initials***

If patient is not insured party- please complete the following:

Insured Party Name: _____ Social Security: _____

Insured Party DOB: _____ Patient Relationship to Insured Party: _____

In the event that my insurance status (including PCP assignment) should change, it is my responsibility to notify North Country of the change. If my insurance does not cover expenses incurred, for any reason, I will be responsible for reimbursement to North Country. I authorize North Country Community Health Center to use the medical or dental records for the above named individual for insurance and statistical purpose. Consent for treatment is given for the above individuals. I also acknowledge receipt of the Health Insurance Portability and Accountability Act (HIPAA) Statement. If there are any exceptions, I have noted them below

Patient or Patient Representative's Signature _____ ***Date:*** _____

Please Turn Over -

NORTH COUNTRY COMMUNITY HEALTH CENTER, INC.
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III. Family Size

Name	Sex	DOB	Marital Status	Social Security Number	Relationship

IV. Sliding Fee Discount Program Requirements- please read and sign below:

Effective today: _____ we need the following documents prior to your next clinic visit:

- Proof of Identification
  - Driver's license or photo identification card
- Proof of Residency
  - Rent, mortgage or lease receipt in the client's name showing the residential address
  - Letter from a non-relative landlord stating that patient resides at address
  - Arizona motor vehicle registration
  - Pay stub with client's name and home address imprinted on it
  - Recent utility bill or US Post Office record showing current address
- Income Verification
  - Current pay stubs (within 30 days)
  - Unearned income (veteran's/military benefits, Social Security benefits, SSI, SSA, child support, etc.)
  - Letter of income verification from employer
  - Income determination worksheet produced by D.E.S, W.I.C, or other state agency, dated within current year and signed by preparer.
  - Current tax return if self-employed
- AHCCCS Status (Based on income and household size, applicants may need to apply to AHCCCS within 7 working days. AHCCCS is State funded and has more comprehensive coverage than our sliding fee discount program.)
  - Letter of acceptance, denial or waiver

IMPORTANT!

*** You are required to apply to AHCCCS, you have 6 weeks to provide the letter of acceptance or denial. All other documentation is required prior to your next clinic visit. Failure to provide all documents will result in you being responsible for 100% of your future medical and dental visits, as well as your prescriptions. By signing below you also certify that the information provided is accurate and that if you willfully falsified this application, you will be disqualified from the program. ***

_____ ***Please initial that you have read and understand and have received a copy of the above requirements.***

I authorize North Country Community Health Center to use the medical or dental records for the above named individual for insurance and statistical purposes. Consent for treatment is given for the above named individuals. I acknowledge that payment for services is my responsibility and assign all insurance benefits to North Country Community Health Center. Delinquent accounts will be sent to collections and a 30% additional premium charge for collection will be applied to the patient's balance. *I also acknowledge receipt of the Health Insurance Portability and Accountability Act (HIPAA) Statement. If there are any exceptions, I have noted them below**

Patient or Patient's Representative Signature: _____ ***Date:*** _____

[redacted] **ADHSPCP OR FEDERAL SLIDE ELIGIBILITY**

Photo ID: _____

Residency: _____

Income: _____

AHCCCS: _____

Total Monthly Verified Income= $_____ Eligible Family Size_____

Slide Category: _____ Co-Pay: $ _____

Income calculation- use 26 for bi-weekly/ 52 for weekly.

$ _____ (Gross Pay) x (26 or 52)/12 =_____

$ _____ (Gross Pay) x (26 or 52)/12 = _____

$ _____ (Gross Pay) x (26 or 52)/12 = _____

Completed by: _____ Date: _____

FAMILY HEALING CENTER
Pediatric History & Physical Form
1401 W. Florida, Holbrook, AZ 86025 Ph: 928-524-2851

DATE

NAME

AGE

DURING MOTHER'S PREGNANCY of weeks &, delivery of this lb. child, was there...

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
High blood pressure?			Multiple gestation (twins,etc)?			Take any medication??		
Diabetes/sugar in mother's urine?			Any infections?			Use tobacco, alcohol?		
Protein in mother's urine?			GC, Syphilis, Chlamydia?			Use other drugs?		
Difficult delivery?			Delay in baby's breathing?			PKU testing?		
Breech delivery? C-section?			Any birth defects?			Sickle Cell testing?		
Did mother breastfeed?			Feed formula?			Any feeding problems?		

PAST MEDICAL HISTORY: has the child had any of the following conditions?

Vision problems?			Stomach problems?			Skills are behind other kids?		
Hearing problems?			Kidney/bladder infection?			School problems?		
Many ear infections?			Joint/Bone problems?			Frequent temper tantrums?		
Hay fever/Sinus problems?			Fracture or dislocation?			Asthma?		
Chronic runny nose or cough?			Any serious injury?			Pneumonia?		
Overweight?			Behavior problems?			Heart problems?		
Underweight/too small?			Constipation?			Seizures?		
Poor appetite?			Doesn't sleep well?			Allergic to any medicine?		
Cries too much?			Wets bed/clothes?			Take prescription medicine?		
Immunization up to date?			Hospitalization?			Meds:		

EXPOSURES

Smoker in the home/sitters?			Solder/silversmith in home?			Tobacco, drugs, alcohol?		
Always use seatbelts?			Batteries?			Miniblinds?		
Potential lead exposure?			Guns?			Other?		

FAMILY HISTORY: Has any blood relative of our child had ...

Allergies?			High Blood Pressure			Diabetes		
Bleeding disorder?			Heart Problems			Tuberculosis (TB)		
Blood Clots?			Strokes			Depression or mental illness		
Cancer?			High cholesterol			Alcoholism or drug addiction		
Lung disease or Asthma?			Heart Vessel surgery			Other serious illnesses?		

SOCIAL HISTORY

Child has how many sisters? ____ Brother? ____	Grade in school? _____
Birth order. ___Oldest ___Middle ___Youngest	Usual grades received (A, B, C, etc.) _____
Who spends most time caring for child?	Who all lives in the home?

ROS:

Provider's Signature: _____

PEDIATRIC PATIENTS CONSENT TO TREAT

Child's Name: _____ Child's Birth date: _____

Consent to Treat Child: Names of people who may bring child if under 18. (Use back if necessary and check here. ☐)

☐ **Alone** without any parent or guardian present (ages 14-17) ☐ **Only with a parent** or guardian in the clinic.

Name	

For Minors under 18 please list additional adult family members helping with child in space below:

Relation: _____

Full Name: _____

Street Address: _____

City/State/Zip _____

Phone: _____

Cell Phone: _____

Relation: _____

Full Name: _____

Street Address: _____

City/State/Zip _____

Phone: _____

Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____

TH COUNTRY
OMMUNITY HEALTH CENTER

1401 W. FLORIDA
HOLBROOK, AZ 86025
PHONE: (928) 524-2851
FAX: (928) 524-2171

Authorization of Use and Disclosure of protected health information

* To be released from: _____
Name(s) and Phone/Fax of person/organization
_____
Address

* To be released to: _____
Name(s) and Phone/Fax of person/organization
_____
Address

Check Information To Be Released

__ All Records __ Immunizations __ Labs __ Dental __ X-rays __ Other

Also Include:

HIV Information Circle **Yes** **No** **Signature** _____

Mental Health Information Circle **Yes** **No** **Signature** _____
(Only client 18 yrs. of age or older or legal representative can authorize release of mental health information)

Substance Abuse Treatment Circle **Yes** **No** **Signature** _____
And assessment Information
(Only client, regardless of age can authorize release of substance abuse information.)
This information has been disclosed to you from records protected by Federal laws and regulations protecting substance abuse treatment program records (42 C.F.C. part 2). The Federal rules that prohibit
You from making any further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Name: _____ Maiden Name: _____
Phone Number ( ) _____ Date of Birth: ____-____-____ SSN: ____-____-____
Address: _____
Signature _____ **Date:** _____

This authorization automatically expires 365 days from the date this form is signed by the patient unless revoked or terminated by patient or patient's personal representative or otherwise noted here ___/___/___.

OFFICE USE ONLY

Proof of identification of person requesting medical records was made through:
Driver's license _____ Other _____
Date __ __/____/____
_____
Signature of Person Verifying Identification