KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Annual Patient Demographics

Dear Patient: The Health Center provides low cost health care regardless of ability to pay. We are the Medicaid provider of choice; and accept Medicare and several insurance products. If you have these products or are "self-pay" you may qualify for a discount called a ***Sliding Fee Scale***. Nominal fees and payment arrangements are also available. To qualify for the "***Sliding Fee Scale***" you must provide Proof of Income and the household occupancy. (See the Sliding Fee Scale Application for further information.) We are required to collect personal information as a part of our FQHC grant agreement which is how we keep costs low. Thank you for your understanding and cooperation in providing this information.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Previous names / aliases: _____ Date of Birth: _____

SSN: _____-_____-_____ Home Phone: _____ Cell Phone: _____

Address: _____ City:_____ State: _____

Zip Code: _____ County: _____ Student Status: ☐ Full Time ☐ Part Time ☐ Does not apply

How do you prefer to be reminded of your appointment: ☐ Text ☐ Call Email Address: _____
By providing email address you are acknowledging authorization to send correspondence by this medium.

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Language: ☐ English ☐ Spanish ☐ Other Do you need an interpreter: ☐ Yes ☐ No

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Race: ☐ White ☐ African American ☐ Asian ☐ Other (Please Specify) _____ ☐ Choose not to disclose

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown or choose not to disclose

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Gender at Birth: ☐ Male ☐ Female ☐ Other: _____

Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Don't Know ☐ Other _____

Primary Care Physician:_____ City / State:_____ Phone: _____

Emergency Contact:

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Emergency Contact Telephone Number:_____

Complete if patient is 18 years of age or younger, attending school, or has a legal guardian:

For all minor patients (18 years of age or under), legal guardians will be asked to show documentation to prove that a legal relationship exists. This is for both the safety of the child and guardian and to ensure that the legally appointed parent or guardian is responsible for making medical decisions on behalf of the minor. Applicable legal documents pertaining to custody, divorce, separation, adoption or name change of parent of child are required.

Parent / Guardian Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Current Custody Status: ☐ Parents ☐ Sole Parental Custody ☐ Joint Legal Custody ☐ DSS Custody ☐ Other: _____

Mailing Address (if different than patient): _____

Insurance Information:

Primary Insurance:	*Secondary Insurance*:
Insurance Company _____	Insurance Company _____
Participant's Name _____	Participant's Name _____
Participant's DOB _____	Participant's DOB _____
Participant's SSN _____	Participant's SSN _____

Sliding Fee Scale: (required for statistical purposes and financial assistance)

List number of people living in house (Please include self):

Adults (over 18 years of age) _____ **Children** (Under 18 years of age) _____

Annual Household Income (please check one): ☐ Less than $15,000 ☐ $15,000 to $24,999 ☐ $25,000 to $34,999 ☐ $35,000 to $49,000 ☐ $50,000 or more

I have reviewed the *Sliding Fee Scale* and I understand that if my financial circumstances change, I can apply for the *Sliding Fee Scale* at any time.

***I *ACCEPT* and have filled out the Sliding Fee Scale Application: _____** (Initial) **(Complete Sliding Fee Application)**

**** I *DECLINE* the Sliding Fee Scale at this time: _____** (Initial) **(Do NOT complete the Sliding Fee Application)**

Living Arrangements:

☐ **Shelter** (Safe havens, temporary overnight housing, armories) ☐ **Transitional** (Center, Community Home) ☐ **Other** (Hotel, motel, day-to-day single room occupancy)	☐ **Doubling Up** (Living with other people for temporary period and move often) ☐ **Street** (Sidewalk, car, park, doorway, public or abandoned building)	☐ **Permanent Residence** (Own, rent, apartment / room / house)

Do you live within Mount Vernon city limits: ☐ Yes ☐ No **Are you a veteran**: ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand that I am responsible to let the doctor or staff know of any changes in my, or minor child's health, or demographic information.

I understand that I am responsible for notifying Knox County Health Center if there is a change in the insurance coverage, address or telephone number. I acknowledge that co-payments or nominal fees are due and payable on the day that services are received.

Name of Patient / Responsible Party (please print): _____ **Date:** _____

Signature of Patient / Responsible Party: _____ **Date:** _____

Annual Review: (***DO NOT*** complete this section – for staff instructed use only)

Signature of Patient / Responsible Party: _____ **Date:** _____

Signature of Patient / Responsible Party: _____ **Date:** _____

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Patient Medical and Dental History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Allergies: I do not have any allergies. _____ (Initial)

I have the following drug, environmental or food allergies (Write name and effect you had)

Drug / Environmental / Food Allergy	***What happens*? (reaction)**
Example: Aspirin	I get a rash.

Medical History: Check if you have or have had problems / history with any of the following:

Cardiac
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Stroke / TIA
- ☐ Heart Transplant
- ☐ Artificial Heart Valves

Circulatory
- ☐ Amputee
- ☐ Blood Clots
- ☐ Peripheral Artery Disease
- ☐ Peripheral Vascular Disease

Dental
- ☐ Bleeding Gums
- ☐ Grinding Teeth
- ☐ Loose Teeth / Broken Fillings
- ☐ Periodental Treatment
- ☐ Tooth Sensitivity

Endocrine
- ☐ Thyroid Disease
- ☐ Diabetes

Gastroenterology
- ☐ Bleeding Ulcers
- ☐ Diverticulitis
- ☐ Gallbladder
- ☐ GERD
- ☐ Hernia

Immune
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Infectious Disease
- ☐ HIV
- ☐ MRSA
- ☐ VRE
- ☐ Hepatitis

Lungs
- ☐ Asthma
- ☐ COPD
- ☐ Obstructive Sleep Apnea
- ☐ Pulmonary Embolism
- ☐ Tuberculosis

Mental / Behavioral Health
- ☐ ADD / ADHD
- ☐ Anxiety / Depression
- ☐ Traumatic Event / PTSD
- ☐ Other: _____
- ☐ Addictions: _____
  _____

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Open Wounds
- ☐ Osteoprorsis

Renal
- ☐ Dialysis
- ☐ Kidney Disease

Cancer
- ☐ No history of cancer
- ☐ Yes, prior history of cancer
- ☐ If Yes: Type: _____
  _____

Name of Last Primary Care Physician Seen (PCP) _____ City / State: _____

Name of Last Dentist Seen: _____ City / State: _____

Surgeries:

Example: Right knee replacement	*When?* 6 years ago

Signature of Patient or Parent/Guardian (If patient is minor): _____ **Date** _____

KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Annual Patient Medication / Drug List

Today's Date _____

Patient Name: _____ **Date of Birth:**_____

ALL PATIENTS: This information will be held in **strict confidence** and will be used only for safe and appropriate care. Please provide the medication/drug name, the dosage you take, and the frequency of which you take the medication / drug. Please use the back of this page if you need more space.

Medications used during treatment may interact with both prescription and non-prescription drugs; including herbal supplements. These reactions may result in **SEVERE INTERACTIONS.** It is **extremely** important that you inform your provider of **any** drug you currently use or may have taken so that this may be considered in planning your treatment.

Conway's Pharmacy and **Wal-Mart of Mt. Vernon Pharmacy** are preferred by the Health Center. Most prescriptions are electronically transmitted for your convenience. Please list **Conway's**, **Wal-Mart** or another pharmacy you prefer.

Pharmacy Name: _____ ***Pharmacy Town:***_____

Medication/Drug	Dosage	How many times a day	What are you taking it for
EXAMPLE: Lisinopril	***10 mg***	***2 MORNING __ NOON ___ DINNER 2 BED***	***High blood pressure***

Annual Consent For Care

Patient Name: _____ Patient Date of Birth: _____

This consent form applies to Knox County Community Health Center (KCCHC) operating as a clinically integrated health care arrangement composed of KCCHC and practitioners collectively. All of the entities owned or operated by KCCHC and all practitioners associated with KCCHC will share medical information of patients as necessary to carry out treatment, payment and health care operations as permitted by law. The KCCHC offers medical, dental, mental health and behavioral health services that I may utilize as a patient of the KCCHC.

CONSENT FOR MEDICAL CARE: I understand that I have the right to make informed decisions about my health care treatment. I consent to have the health care professionals at KCCHC perform the appropriate services and treatments, which may include routine diagnostic procedures and such medical / dental treatment as the named attending practitioner or other member of the medical / dental staff consider to be necessary. I understand that the practice of medicine / dental / behavioral health is not an exact science and that diagnosis and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of any examination or treatment. I understand that it is customary that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the practitioner or other health professional and the patient has given their informed consent for that particular procedure. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course. I understand that my health care providers work as a team, and that in order to provide me with the best care, my attending practitioner and other health providers may consult with or make referrals to providers in other specialties, as appropriate, such as other Physicians, Dentists / Oral Surgeons, Pharmacists, Dieticians, Therapists, etc., including obtaining my medication history from various prescription databases. I know that I can ask any KCCHC health care professional that treats me questions about my treatment.
I understand that some medical providers on the staff of the KCCHC are not employees or agents of the KCCHC but are independent contractors who have been granted the privileges of using the facilities for the care and treatment of their patients.
KCCHC participates in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. KCCHC, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the office administrator.

ASSIGNMENT OF INSURANCE BENEFITS: I understand that charges are made for KCCHC services provided by the health center staff and its Affiliated Physicians / Dentists / Behavioral Health. I also understand that, if these charges are covered by insurance or other third-party reimbursement of any type, I hereby authorize assignment of these benefits to KCCHC and its Affiliated Physicians / Dentists. I authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.
It is the policy of the KCHC to provide essential medical, mental health, behavioral health and dental services regardless of the patient's ability to pay. I understand and agree that some services rendered are based on my ability to pay. If qualified, a discount may be applied to co-payment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale", I must provide proof of household income and the household occupancy. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of services rendered at the time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.
PERSONAL VALUABLES: I understand and agree that the KCCHC shall not be liable for the loss or damage to any personal property.
I authorize KCCHC and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.
ATTENTION PARENTS & GUARDIANS: If you are signing on behalf of a minor, please be aware that under certain circumstances, state and federal laws may determine that the minor controls the protected health information relating to certain aspects of the minors care or treatment. In this event, KCCHC may not release the applicable protected health information without the minor's consent.

By signing below, I acknowledge that I have read and understood this form, or had this form read and explained to me. I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Who may we discuss and share your health records with? *I give KCCHC authorization to share my health records with:*

Name: _____ *Phone:* _____

Name: _____ *Phone:* _____

_____ _____

Date / Time **Signature of Patient/Parent/Guardian/Other** **Relationship if Other than Patient**

_____

Date / Time **Witness Signature**