Children's Heart Center of Central Oregon
Patient Registration

Patient information

Name: LAST _____FIRST _____MIDDLE_____
DOB: _____ Gender: ☐Male ☐Female ☐Other
Pronoun: ☐he/him ☐she/her ☐they/them ☐other, please specify: _____
Patient address: _____
Cell phone (if applicable): _____

Parents/Guardians

1) Name: LAST _____FIRST _____
   Relationship: ☐mother ☐father ☐other (please specify_____)
   Cell phone: _____ Other phone: _____
   Address (if different from above):_____
   Email: _____
   ☐Primary contact (the person we should contact with appointment confirmations, test results, etc.)
2) Name: LAST _____FIRST _____
   Relationship: ☐mother ☐father ☐other (please specify_____)
   Cell phone: _____ Other phone: _____
   Address (if different from above):_____
   Email: _____
   ☐Primary contact (the person we should contact with appointment confirmations, test results, etc.)
3) Name: LAST _____FIRST _____
   Relationship: ☐mother ☐father ☐other (please specify_____)
   Address (if different from above):_____
   Email: _____
   Cell phone: _____ Other phone: _____
   ☐Primary contact (the person we should contact with appointment confirmations, test results, etc.)
4) Name: LAST _____FIRST _____
   Relationship: ☐mother ☐father ☐other (please specify_____)
   Address (if different from above):_____
   Email: _____
   Cell phone: _____ Other phone: _____
   ☐Primary contact (the person we should contact with appointment confirmations, test results, etc.)

For primary contact:
If we are unable to reach you by cell phone, please select all that apply:

☐We may text you
☐We may send an email to you
☐We may leave a message on your answering machine at home
☐We may leave a message with another parent/guardian

Responsible Party

Name: LAST _____FIRST _____
DOB: _____ Gender: ☐Male ☐Female ☐Other
If not listed above:
Address: _____
Cell phone: _____ Other phone: _____

Insurance Information

Insurance	ID Number	Subscriber Name	Subscriber DOB
Primary			
Secondary			

Emergency Contact, if not listed above:
Name: LAST _____FIRST _____
Relationship: _____
Address:_____
Cell phone: _____ Other phone: _____

Any individuals not listed above who are permitted to seek medical care for my child:

Name	Relationship to child

FINANCIAL AGREEMENT

I, the undersigned,

☐do not have insurance coverage
☐have insurance coverage and authorize direct payment to the Children's Heart Center of Central Oregon

I acknowledge that I will be financially responsible for all charges, whether or not paid by insurance. **A 10% annual charge will be assessed for invoices not paid within 30 days.** Invoices not paid within 90 days may be sent to collections. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. In addition, I authorize CHCCO to release information, as necessary, in order to facilitate treatment, payment, or other healthcare operations.

I understand that a fee of $100 will be charged for missed appointments ("no shows") and appointments that are not cancelled within a 24-hour advance notice.

Signature: _____ Date:_____

Print Name: _____

Patient Name: _____ DOB: _____

MISSED APPOINTMENT (NO-SHOW) POLICY

Patient Name: _____ DOB: _____

Please **read carefully**, and **initial** below:

At CHCCO, our goal is to provide excellent service in a timely manner, and we need your help.

Canceled appointments, missed appointments, and arriving late for an appointment all affect our ability to stay open, on schedule, give timely appointments to patients who need them, and provide an excellent level of care. We make an effort to be accommodating in our scheduling, so that the needs of our patients can be met. Although we have always asked our patients and their families to notify us if they will be unable to make their appointment, circumstances have made it necessary for us to implement a Missed Appointment Policy. We want to make certain that appointments are kept available for those patients who need and desire them.

_____(initial) If I am unable to come to my appointment, I will notify CHCCO as soon as possible, and no later than **24 hours** before the appointment.

_____(initial) If I don't show for an appointment, or if I reschedule within 24 hours of my appointment, I will be charged a fee of $100, and this will not be covered by my health insurance plan.

_____(initial) If I am more than 15 minutes late for an appointment, the appointment may need to be rescheduled.

_____ (initial)Patients with multiple no-shows will not be rescheduled, so that appointment times can be made available to those who need and desire them.

I, (print)_____ (patient or responsible party), acknowledge that I have read and understand the statements above, and that I am responsible for charges to my account.

_____ _____

Signature Date

Children's Heart Center of Central Oregon

HIPAA ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB:_____

The Privacy Act of the Health Information Portability and Accountability Act (HIPAA) of 1996 was placed into effect to protect your Personal Health Information (PHI) from being disclosed to unauthorized persons.

The HIPAA Notice available on our website (hard copies available at our clinic location) is our privacy policy, and explains how your PHI may be used or disclosed as well as your rights for access and control of your PHI. This Notice is effective going forward. A new acknowledgement form will be reissued if there are significant changes to this policy.

Please sign this form to acknowledge that you have received and read a copy of our privacy policy, or that you have declined to read a copy. If you have any questions regarding the privacy policy, please ask a member of our staff.

Form completed by (print)_____ for the above patient.

Signature: _____ Date: _____

FETAL CARDIOLOGY CLINIC
NEW PATIENT QUESTIONNAIRE

Name: _____
Date of Birth: _____ Age: _____
Reason for referral:
_____

Regarding this pregnancy:
Who is your obstetrician? _____
What is your gestational age at time of appointment with us? _____weeks
What is your expected due date? _____
What is your expected delivery location? □ St. Charles – Bend
□ Other _____

Have you had any complications during this pregnancy?
_____
_____
Who will be your baby's primary care provider?
_____

Past Pregnancy History:
Including this time, how many times have you been pregnant? _____
How many living children do you have? _____
Have you had any miscarriages or stillbirths? □ Yes □ No
If yes, at how many weeks? _____
Have you had any other past pregnancy complications? □ Yes □ No
If yes, please explain:
_____
_____

Past Medical History:
Do you have any personal history of heart conditions? □ Yes □ No
If yes, please explain:
_____
_____
Are you taking prenatal vitamins? □ Yes □ No
Are you taking any other medications? □ Yes □ No
If yes, please list:
_____
_____

Do you have any chronic medical conditions? □ Yes □ No
If yes, please explain:

_____

_____

Have you had any previous hospitalizations? □ Yes □ No
If yes, please explain:

_____

_____

Family History (please answer for baby's mother's family and baby's father's family):
Have any family members had the following:

□ Born with a congenital heart defect
□ Sudden death in an infant, child, or young adult
□ Heart rhythm abnormalities
□ Genetic syndromes

If yes, please explain:

_____

_____

Social History:
Marital status: □ Married □ Single □ Divorced □ Widowed
Please list children living with you and their ages:

_____

_____

Highest level of education completed: _____
Occupation: _____

Will the father of the baby be involved in the baby's care? □ Yes □ No
Occupation of father of baby, if applicable: _____
If surrogate pregnancy, location of baby's parents: _____

Smoking history: □ Never □ Not during this pregnancy
□ Yes; list amount/frequency: _____
Recreational drug use: □ Never □ Not during this pregnancy
□ Yes; list amount/frequency: _____
Alcohol use: □ Never □ Not during this pregnancy
□ Yes; list amount/frequency: _____

Is there anything else you would like us to know?

_____

_____

Date: _____

Patient's Name: _____ DOB: _____

Covid-19 Questionnaire

Because Covid-19 infection and vaccination can affect the heart, it is helpful for us to know your Covid history. Please answer the following questions to the best of your ability.

1. Has the patient been vaccinated against Covid-19?
   - ☐ No
   - ☐ Yes: ☐ Pfizer ☐ Moderna ☐ J&J
     - ☐ One shot
     - ☐ Two shots
     - ☐ Two shots plus booster

   Approximate date of last vaccine: _____

2. Has the patient had a Covid-19 infection?
   - ☐ No
   - ☐ Yes

   If yes:
   Approximate date of infection: _____
   Any symptoms during infection? ☐ No ☐ Yes

   Hospitalized? ☐ No ☐ Yes
   How many days of fever? _____

   If patient had symptoms:

Symptom	**Had during illness**	**Still present**
Cough	☐	☐
Congestion/runny nose	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Muscle aches	☐	☐
Loss of taste/smell	☐	☐
Sore throat	☐	☐
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Fatigue	☐	☐
Headache	☐	☐