

**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: \_\_\_\_\_

**Children's Heart Center of Central Oregon  
Patient Questionnaire**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name patient likes to be called, if different from above: \_\_\_\_\_ Age: \_\_\_\_\_

Who is with the patient at today's visit?

- |                                     |                                      |  |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Mother     | <input type="checkbox"/> Stepfather  | <input type="checkbox"/> Foster parent |
| <input type="checkbox"/> Father     | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Friend        |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Aunt/uncle  | <input type="checkbox"/> Other _____   |

What is the main question or concern that we can help you with today?

\_\_\_\_\_

Which of the following symptoms are experienced by the patient?

*Babies/toddlers only:*

- ☐ Poor feeding
- ☐ Sweating with feeds
- ☐ Poor weight gain
- ☐ Unusual irritability

*All patients, including babies/toddlers:*

- ☐ Turning blue
- ☐ Breathing difficulty
- ☐ Trouble with exercise/activity
- ☐ Abnormal fatigue
- ☐ Fainting
- ☐ Chest pain
- ☐ Palpitations (fast or abnormal heartbeats)
- ☐ Dizziness/lightheadedness
  
- ☐ **No symptoms at all**

*Development (all patients):*

Do you have concerns about the following:

- ☐ Motor or language skills
- ☐ Social or emotional development
- ☐ Learning/academic skills
- ☐ Behavior

**PREGNANCY/MEDICAL HISTORY**

- ☐ I don't know details about the pregnancy or delivery. (If you don't know, please continue to **hospitalizations** below.)

Patient was born ☐ on time ☐ prematurely (at how many weeks? \_\_\_\_\_)

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Pregnancy complications (check all that apply, and give any applicable details in space provided):

- ☐ Maternal illness
- ☐ Maternal tobacco use
- ☐ Maternal drug use
- ☐ Maternal alcohol use
- ☐ Medications other than prenatal vitamins
- ☐ Other complications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were there any problems during delivery? ☐ No ☐ Yes (please explain below:)

\_\_\_\_\_

Newborn complications (check all that apply, and give any applicable details in space provided):

- ☐ Baby needed oxygen (how long \_\_\_\_\_)
- ☐ Baby was on ventilator (how long \_\_\_\_\_)
- ☐ Diagnosis of genetic syndrome
- ☐ Diagnosis of heart defect
- ☐ Other newborn complications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Hospitalizations.** Not including emergency room or urgent care visits, has the patient been hospitalized? ☐ No ☐ Yes

If yes, please provide details (please include surgical procedures):

<u>When?</u>	<u>Where?</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list current medications and reasons for taking:

Medication

Reason

_____	_____
_____	_____
_____	_____

Medication

Reason

_____	_____
_____	_____
_____	_____

Allergies:

☐ None

☐ Drug allergies \_\_\_\_\_

☐ Other allergies \_\_\_\_\_

Are patient's immunizations up to date?

☐ Yes

☐ No; reason: ☐ Catching up ☐ Religious ☐ Parent choice ☐ Other

## FAMILY HISTORY

Check all that apply (parents, siblings, aunts, uncles, cousins, or grandparents), and provide details in space provided:

*What:*

- ☐ Born with heart defect
- ☐ Heart rhythm abnormality
- ☐ Sudden death at young age
- ☐ Fainting
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Early heart attack (what age?)
- ☐ Hypertension
- ☐ Asthma
- ☐ Other

*Who/any other details:*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

## SOCIAL HISTORY

Who does patient live with (check all that apply)?

- ☐ Biological mother
- ☐ Biological father
- ☐ Sibling(s); how many \_\_\_\_\_
- ☐ Shared custody
- ☐ Adoptive parent(s)

- ☐ Stepmother
- ☐ Stepfather
- ☐ Grandmother
- ☐ Grandfather
- ☐ Foster parent

- ☐ Friend
- ☐ Aunt
- ☐ Uncle
- ☐ Other \_\_\_\_\_

Does anyone at home use tobacco? ☐ No ☐ Yes

Mom's occupation:

Dad's occupation:

Other primary caregiver occupation:

Other primary caregiver occupation:

*School (check all that apply):*

- ☐ Not in school yet
- ☐ Grade K-12 ⇒ Which grade \_\_\_\_\_ Name of school: \_\_\_\_\_
- ☐ Home school (grade level \_\_\_\_\_)
- ☐ Currently not in school
- ☐ Graduated from high school
- ☐ College ⇒ Major \_\_\_\_\_ Name of school: \_\_\_\_\_

☐ Preschool/prekindergarten

☐ Online school

☐ Has GED

*Physical activity:* Is patient active in sports (check all that apply)?

- ☐ Not active at all
- ☐ Active play (young children)
- ☐ Recreational sports (friends, parks and rec, etc.)(which sports \_\_\_\_\_)
- ☐ Competitive sports through school (which ones \_\_\_\_\_)
- ☐ Competitive club sports (which ones \_\_\_\_\_)
- ☐ Individual sports/workouts (what type \_\_\_\_\_)
- ☐ Other \_\_\_\_\_

Any trouble keeping up with peers during exercise? ☐ Yes ☐ No

Does patient use any of the following:

- ☐ Tobacco  
☐ Recreational drugs; which ones: \_\_\_\_\_

- ☐ Alcohol  
☐ Energy drinks  
☐ Other caffeine (pop/tea/coffee/pills)  
☐ Vaping

☐ Supplements; which ones: \_\_\_\_\_

☐ Cold medications; which ones: \_\_\_\_\_

☐ Exposed to second hand tobacco at home

## REVIEW OF SYSTEMS

Is the patient experiencing any of the following symptoms or problems? Please check all that apply, and explain in comment section below.

<b>GENERAL</b>	<b>NONE</b> <input type="checkbox"/>	<input type="checkbox"/> weakness	<input type="checkbox"/> fever	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain
<b>SKIN</b>	<input type="checkbox"/>	<input type="checkbox"/> rash	<input type="checkbox"/> color change		
<b>EYES</b>	<input type="checkbox"/>	<input type="checkbox"/> nearsighted	<input type="checkbox"/> farsighted	other vision problems (explain below)	
<b>EARS/NOSE/THROAT</b>	<input type="checkbox"/>	<input type="checkbox"/> ear infections <input type="checkbox"/> hearing problems <input type="checkbox"/> bleeding gums	<input type="checkbox"/> sinus infections <input type="checkbox"/> nasal discharge <input type="checkbox"/> bloody noses	<input type="checkbox"/> crowding of teeth <input type="checkbox"/> cavities/other dental issues; please explain below	
<b>SLEEP</b>	<input type="checkbox"/>	<input type="checkbox"/> snoring	<input type="checkbox"/> irregular breathing during sleep	<input type="checkbox"/> difficulty sleeping	<input type="checkbox"/> daytime sleepiness
<b>LUNGS</b>	<input type="checkbox"/>	<input type="checkbox"/> cough	<input type="checkbox"/> wheezing	<input type="checkbox"/> noisy breathing	<input type="checkbox"/> coughing up blood
<b>GASTROINTESTINAL</b>	<input type="checkbox"/>	<input type="checkbox"/> nausea <input type="checkbox"/> vomiting	<input type="checkbox"/> constipation <input type="checkbox"/> diarrhea	<input type="checkbox"/> abdominal pain <input type="checkbox"/> abdominal swelling	<input type="checkbox"/> bloody stools
<b>URINARY</b>	<input type="checkbox"/>	<input type="checkbox"/> blood in urine	<input type="checkbox"/> painful urination	<input type="checkbox"/> frequent urination	
<b>MENSTRUAL (females only)</b>	<input type="checkbox"/>	<input type="checkbox"/> menstrual irregularity	<input type="checkbox"/> excessive menstrual cramping		
<b>MUSCULOSKELETAL</b>	<input type="checkbox"/>	<input type="checkbox"/> scoliosis <input type="checkbox"/> back pain	<input type="checkbox"/> joint swelling	<input type="checkbox"/> joint pain (please explain below)	
<b>ENDOCRINE</b>	<input type="checkbox"/>	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> heat/cold intolerance	<input type="checkbox"/> change in appetite (please explain below)	
<b>HEMATOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/> anemia or low iron	<input type="checkbox"/> easy bruising	<input type="checkbox"/> abnormal bleeding	<input type="checkbox"/> blood clots
<b>NEUROLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/> seizures <input type="checkbox"/> headaches	<input type="checkbox"/> poor coordination <input type="checkbox"/> numbness	<input type="checkbox"/> difficulty walking <input type="checkbox"/> difficulty speaking	<input type="checkbox"/> tingling
<b>PSYCHOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/> depression <input type="checkbox"/> anxiety	<input type="checkbox"/> mood changes	<input type="checkbox"/> attention deficit <input type="checkbox"/> hyperactivity	<input type="checkbox"/> unusual stress

Comments, or anything else you would like us to know:

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### 3-Day Food Diary

Food Diary For (Name): \_\_\_\_\_

Please complete this diary for all **food AND drink** consumed 3 days in a row. Please do not change your diet just because you are writing it down.

[illegible]



[illegible]