

**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: _____ Other primary caregiver occupation: _____

Dad's 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.

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

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