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?

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Grandparent
- ☐ Aunt/uncle
- ☐ Foster parent
- ☐ Friend
- ☐ 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

Development (all patients):
Do you have concerns about the following:

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

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**

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):

When?	Where?	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:	*Who/any other details:*
☐ 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	_____

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.

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

Comments, or 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	☐	☐