Patient Name: _____ Date of Birth: _____

NORTHWEST COLORADO HEALTH

PATIENT REGISTRATION FORM

Patient Information

Legal Name* Last	First	Middle Initial	**Preferred Name:**	
Previous Name Last	First	Middle Initial		
Date of Birth ***Month Day Year***		**Social Security #**		
Home Phone		**Cell Phone**		
Patient Reminder Call and Notification Preference ☐ Voice Call ☐ Text **Preferred Phone:** ☐ Home or ☐ Cell *(Cell must be indicated for TEXT)*				
Email Address				
Mailing Address City		State Zip		
Physical Address (if different from mailing) City		State Zip		
Emergency Contact's Name Phone Number		Relationship to Patient		

Guardianship Information *(If you are not the biological parent, please provide legal documentation showing guardianship)*

Name	***Relationship***	***Address (if different from Patients)***	***Email (Required for Portal Proxy account)***	***Phone***

Insurance Information

Do you have insurance: Yes No **Name of your insurance company:** _____ *It is your responsibility to present your insurance card to front desk.*
Insurance Payments: We participate in assignment of payment with **specific** insurances (posted at the front desk) in our area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan. You are responsible for any unpaid balances left on your account regardless of the amount of insurance coverage.
Patient Copays: Patient copays are expected at time of service for all appointments

Insurance Responsible Party Information (For all patients under age 18)

Name	Phone Number	Relationship to Patient	Date of Birth
Mailing Address	City	State	Zip

PHI – Authorized Disclosure Consent (continued on 2nd page)

I authorize Northwest Colorado Health to discuss with the following individual(s) PHI regarding my current care and treatment:		
Name	Phone Number	Relationship to Patient

Name	Phone Number	Relationship to Patient
The following information may be communicated verbally to the individual(s) named above:		

Staff Initials: _____ Revision: April 2021 Patient Name: _____ Date of Birth: _____

Continued from page 1 - PHI

☐Laboratory Results ☐Billing, Insurance, and Payments

☐Medical Instructions or Advice ☐Adult Family Planning Treatment, Instructions, or Advice

☐Appointment Information ☐Dental Treatment, Instructions, or Advice ☐Prescription Drug Information

I Understand That

- The information to be released verbally may not include a diagnosis or reference to the following condition(s): *Behavioral Health services/psychiatric care; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV);*
- Without my express revocation, this authorization will automatically expire 1 year from the date signed below, unless I request an expiration date less than 1 year.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy rule.

Demographic Information

1) Sex at birth
- ✈ Female
- ✈ Male

2) Current Marital Status
- ✈ Married
- ✈ Partnered
- ✈ Single
- ✈ Divorced
- ✈ Legally Separated
- ✈ Widowed

3)Student Status
- ✈ Full Time Student
- ✈ Part-time student
- ✈ Not a student

4) Employment Status
- ✈ Full-time
- ✈ Part-time
- ✈ Not-employed
- ✈ Self-employed
- ✈ Retired
- ✈ Active Military Duty
- ✈ Reserved for National Assignment

Employer:

5) Pharmacy of Choice:

_____
Name

_____
City/State

6) Gross annual (before taxes) household income? (include spouse)

$_____ ☐ No income

6a) How many people (including yourself) does your income support? (if you are pregnant count unborn baby(ies)

_____

7) Race (check all that apply)
- ✈ African American / Black
- ✈ Asian
- ✈ Caucasian / White
- ✈ Native American / Alaskan Native / Inuit
- ✈ Pacific Islander
- ✈ Other, Please Specify:

_____

8) Ethnicity
- ✈ Hispanic/Latino/Latina
- ✈ Not Hispanic/Latino

9) **Migrant?**
- ✈ Yes
- ✈ No

10) **US Veteran?**
- ✈ Yes
- ✈ No

11) United States Citizen or Legal Immigrant?
- ✈ Yes
- ✈ No

12) Public Housing Resident?
- ✈ Yes
- ✈ No

13) Homeless	14) Gender Identity	15) Sexual Orientation?	16) Referral Source
✈ Not Homeless (has permanen established residence) ✈ Primary Residence is Supervised Private or Public Facility ✈ Transitional Housing ✈ Lives on Street ✈ Lives in Car ✈ Lives at a Shelter ✈ Stays with Family/Friends ✈ Other, Please Specify: _____	✈ Female ✈ Male ✈ Transgender F❼M ✈ Transgender M❼F ✈ Other ✈ Choose not to disclose	✈ Straight ✈ Lesbian or Gay ✈ Bisexual ✈ Something Else ✈ Don't know ✈ Choose not to disclose	✈ Self ✈ Friend or Family Member ✈ Health Provider ✈ Emergency Room ✈ Internet/newspaper/radio ✈ Other _____

I hereby certify that all of the information given, including income, is correct.

_____ _____/_____/_____ _____

Signature Month / Day / Year Relationship to patient if not self

Staff Initials: _____

Revision: April 2021

NORTHWEST COLORADO HEALTH

DENTAL HEALTH HISTORY FORM

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

Existing Patients: Please check this box and initial if your health history has NOT changed in the last 12 months ☐ _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes: _____

Preferred Pharmacy: _____ **City, State**: _____

Medication / Supplement	**Dosage/Strength, Frequency**
Allergies	**Reaction**

Are you current on your immunizations: ☐ YES ☐ NO ☐ UNSURE

General Health History – Check if you have had any of the following							
AIDS/HIV Positive		Cortisone Medication		Hepatitis B or C		Sinus Trouble	
Alzheimer's Disease		Diabetes I or II		High Blood Pressure		Stroke	
Angina		Emphysema		Low Blood Pressure		Substance Abuse	
Artificial Heart Valve		Fainting/Dizziness		Mitral Valve Prolapse		Thyroid Disease	
Artificial Joint		Hearing Problems		Pain in Jaw Joints		Vision Problems	
Asthma		Heart Pacemaker		Rheumatic Fever			
Cancer		Heart Trouble/Disease		Serious Head Injury			
Chemotherapy		Hemophilia		Serious Neck Injury			
Cold Sores/Fever Blisters		Hepatitis A		Sickle Cell Disease			
COPD							
Other:							

Has a physician or previous dentist recommended that you take antibiotics prior to your dental appointments?	☐ YES ☐ NO If Yes, please explain:

Women: Are you….	☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Surgical History	
Date	**Type of Surgery / Procedure**

Medical / Psychiatric Hospitalization History	
Date	**Reason for Hospitalization**

Revised: 12/6/2018

Family History

Family Member	Status	How Old?	Medical / Mental Health Illness / Disease
Father	Alive / Deceased		
Mother	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Paternal Grandmother	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Maternal Grandmother	Alive / Deceased		
Sister(s)	Alive / Deceased		
Brother(s)	Alive / Deceased		
Children	Alive / Deceased		
Other Relatives	Alive / Deceased		

Social History

Do you have access to food on an ongoing basis?	☐ YES ☐ NO
Do you have access to safe and secure housing?	☐ YES ☐ NO
Do you have access to transportation to get to your medical appointments?	☐ YES ☐ NO
If you have guns in your house, are they locked and unloaded?	☐ YES ☐ NO ☐ N/A
Have you ever been hit, slapped, kicked, shaken or hurt by anyone including significant others?	☐ YES ☐ NO
Is there anyone that makes you feel unsafe now?	☐ YES ☐ NO
Do you currently or have you ever experienced Sexual Abuse?	☐ YES ☐ NO
Do you often feel lonely?	☐ YES ☐ NO
Are you concerned about your memory or ability to do daily activities on your own?	☐ YES ☐ NO
Do you feel uncomfortable in social settings or in groups of people?	☐ YES ☐ NO

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

NORTHWEST COLORADO HEALTH

Minor Consent for Treatment

We at Northwest Colorado Health feel it is important for a guardian of a minor child to attend all visits but realize this may not be possible. This form may be used to allow an adult other than a parent to serve as a proxy/decision maker (delegate) for routine medical care and services at Northwest Colorado Health during follow up appointments. This form may also be used to grant permission to a minor child to be treated by Northwest Colorado Health without the presence of a parent, legal guardian or appointed proxy/decision maker. (Please note: A minor child may obtain Family Planning Services, including, among other services, contraception, STD testing, pre-natal and other pregnancy care, breast and pelvic examinations, behavioral health, or treatment for addiction or use of drugs or alcohol, without obtaining Parental permission.) Additionally, minors who are married or pregnant may make health decisions without the permission of a parent or legal guardian.

If you would like to appoint a proxy decision maker, please review and complete the following form authorizing a proxy decision maker to consent to and authorize medical treatment or services for and to be involved in the care of a minor child. A proxy must be 18 years of age or older. You do not need to complete this form to appoint a legal guardian as a proxy.

AUTHORIZATION:

I/We as the parent/legal guardian(s) of minor child:

_____ _____

Minor's Name Date of Birth

give my/our consent for emergency and routine medical, dental, and behavioral health treatment per the judgement of the treating provider **regardless of who brings the patient to the clinic** (as long as they are at least 18 years of age).

Exception: list person(s) who may not bring minor in.

_____

Exception 1

_____

Exception 2

I (we) have the legal right to delegate such consent. I understand that protected health information may be shared with the proxy to facilitate informed decision making and hereby agree to the sharing of same.

LIMITATIONS

Please identify any specific limitation on the kinds of medical services for which this authorization is given.

☐ None ☐ Limitations:

_____

_____

_____

Please turn over

Patient Name: _____ Date of Birth: _____

PARENT IDENTIFICATION

Parental contact information for questions regarding treatment:

_____	_____	_____
Parent Name	Phone Number	Alternate Phone Number
_____	_____	_____
Parent Name	Phone Number	Alternate Phone Number

I (we) hereby indemnify and hold harmless Northwest Colorado Health, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Northwest Colorado Health. Only one parent's signature is required.

_____	_____
Signature of Parent or Legal Guardian	Date

NORTHWEST COLORADO HEALTH DENTAL CLINIC

Patient Name: _____ DOB: _____

COVID-19 Pandemic Dental Treatment Consent Form

I,_____, knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I have been made aware of the Center for Disease Control guidelines, the recommendations of the Colorado Dental Association, American Dental Association, and Local/State Public Health Mandates.

Procedure Issues

_____Due to the extreme nature of this pandemic, I understand that post-operative monitoring is difficult and that my doctor may opt to perform these services remotely.

_____After my procedure, I understand that I may be at higher risk for further infection and agree to remain at home and will seek medical attention if I become symptomatic for COVID 19 including but not limited to loss of taste or smell, fever, shortness of breath, dry cough, runny nose, sore throat.

_____ I understand that to mitigate these risks, it is imperative that I take the medications as prescribed. I further understand that certain medications, such as opioid "pain" medications, cannot be called into pharmacies.

Unique Circumstances

_____Dental procedures create water spray (aerosol), which is how the disease is spread. The ultra- fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

_____I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limits in virus testing.

_____I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus by being in a dental office.

_____ I confirm that I do not have any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, runny nose, sore throat currently, or for the last 14 days.

_____I confirm that I have not been in contact with a person that has been diagnosed with COVID- 19 within the last 14 days.

_____ I understand that the CDC recommends social distancing of at least 6 feet to prevent transmission of disease and this is not possible with dentistry.

_____I agree that, if I were to exhibit any symptoms of, or am diagnosed with, COVID-19, I will immediately contact my dentist so that proper steps can be taken to limit the spread of this contagion.

_____I hereby acknowledge that no guarantee, warranty, or assurance has been given to me that the proposed treatment will be completely successful. It is anticipated that the treatment will provide benefit. However, due to

individual patient differences, there exists a risk of failure relapse, selective retreatment, or worsening of my present condition, including the loss of additional teeth/bone, despite the best care.

I have read, comprehend, and agree with the above statements.

_____ _____

Patient / Guardian Signature Date

NORTHWEST COLORADO HEALTH

Patient Name:_____Date of Birth: _____

By signing this form, I acknowledge receipt of the policies listed below:

- **Conditions of Admission and Authorization for Treatment**
- **Late and Missed Appointment Policy**
- **Client's Bill of Rights and Responsibilities**

_____ ____/____/____

Signature Month/ Day / Year

_____

Relationship to patient if not self

For patients participating in our School-Based Health services: Primary Care, Dental, Behavioral Health:

Student Records Reasonably Related and Necessary for the Provision of the Health Care Services: I hereby permit Northwest Colorado Health to use, and receive from patient's respective School District, student records of my student that are reasonably related to, and necessary for, Northwest Colorado Health's provision of School-Based Health services to my student. I also hereby permit the patient's respective School District to release and provide to Northwest Colorado Health student records of my student that are reasonably related to, and necessary for, Northwest Colorado Health's provision of School-Based Health services to my student.

_____ ____/____/____

Signature Month/ Day / Year

_____

Relationship to patient if not self

NORTHWEST COLORADO HEALTH

Patient Name: _____ Date of Birth: _____

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT FORM

Our Notice of Information Practices provides information about how we use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Agency provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I, _____ understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations (TPO).
- The Agency has a Notice of Information Practices and that I was given the opportunity review this Notice.
- The Agency reserves the right to change the Notice of Information Practices.
- I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out TPO but that The Agency is not required to agree to these restrictions.
- I understand that I may revoke this consent in writing at any time and all future disclosures will then cease.

_____ _____/_____/_____

Signature Month / Day / Year

_____

Relationship to patient if not self