Cherokee HEALTH SYSTEMS

Registration

(Please Print)

For Office Use Only
Location:
Med Record #:
Date:

Patient's Name: *First* *Last*	Birthdate:	SSN:

Consent to Evaluation and Treatment

Cherokee Health Systems (CHS) is dedicated to providing comprehensive primary care, dental and behavioral health services. Because wellness involves both the body and mind, our multidisciplinary team of providers work together to offer you high quality whole person healthcare. In order to provide you with comprehensive and coordinated care, your providers may involve other healthcare specialists as part of your care team. Members of your health care team will collaborate and share clinical information as needed to ensure enhanced continuity of care.

Some services at Cherokee Health Systems may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These services utilize high-speed electronic connections and incorporate healthcare industry-standard encryption and data security methods. While there is no guarantee these transmissions cannot be intercepted, great care is taken to prevent all unlawful access to electronic data.

I understand, that if I am 16 years of age or older, I may consent for certain types of health services, including mental health services; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent to services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation and treatment for myself and/or child(ren) as set forth above, including any studies or procedures that CHS professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

Patient's Signature (or legal guardian, if applicable) **X**_____	Date _____
Type or Print Name **X**_____	Date _____
Witness **X**_____	Date _____

Are you homeless or living in a temporary home (relative/friend's house)?	☐ Y ☐ N
Do you live in government provided public housing?	☐ Y ☐ N
Are you a Veteran?	☐ Y ☐ N
Hearing Impaired?	☐ Y ☐ N If Yes, Interpreter needed? ☐ Y ☐ N
Race?	☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Black/African American ☐ Hispanic Latino ☐ White ☐ Other Pacific Islander ☐ Decline to Report
Ethnicity?	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Report
Are you or your family member a migrant or seasonal worker who has worked on a farm or in a produce within the past 2 years?	☐ Y ☐ N Migrant ☐ Y ☐ N Seasonal ☐ Y ☐ N Aged or disabled Former agricultural worker
What is your sexual orientation? ☐ Bisexual ☐ Gay or Lesbian ☐ Straight/Not Gay or Lesbian ☐ Something Else ☐ Don't Know ☐ Decline to Report	What is your gender identity? ☐ Male ☐ Trans female/male to female ☐ Other ☐ Female ☐ Trans male/female to male ☐ Decline to Report

Statement of Privacy Practices/Client Rights and Grievance Procedures/ Well-Child/TENNder Care Programs

My initials below serve as my signature confirming I was provided materials listed.

I have received Cherokee Health System's *Statement of Privacy Practices*.	Patient Initials **X**_____
I have received Cherokee Health System's *Client Rights and Grievance Procedures* and understand my rights will be explained to me upon request.	Patient Initials **X**_____
If under the age of 21, I have received information about *Tennessee's EPSDT Program-TennCare Kids and Cherokee Health System's Well-Child Program.*	Patient Initials **X**_____

For office Use Only

I provided (Patient's Name) _____ a copy of the following:

- ☐ CHS's Statement of Privacy Practices
- ☐ CHS's Client Rights and Grievance Procedures
- ☐ Tennessee's EPSDT Program-TennCare Kids and CHS's Well-Child Program (if under the age of 21)

Patient's Name: *First* *Last*	Birthdate

Contact Information

Patient Address	City/State/Zip Code	Phone #
		( )

Emergency Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

Contact Name/Relationship	Contact Address	City/State/Zip Code	Contact Phone #
			( )

Information to Release to Contact Please check all that apply below

☐ Appointment ☐ Financial/Billing ☐ Pharmacy Pick-up ☐ Emergency Information ☐ Lab Results

I authorize Cherokee Health Systems to leave messages on the answering machine(s) at my contact number(s).

☐ Y ☐ N

I give my permission for my provider(s) with Cherokee Health Systems to communicate [orally or written (i.e. summary letter)] with the following individual(s) in regard to:

☐ Examination ☐ Diagnosis ☐ My Treatment ☐ Specific Purpose:_____	Contact Name: Phone:	Relationship to Patient:
	Contact Name: Phone:	Relationship to Patient:

By signing below, I authorize Cherokee Health Systems to release information concerning me, my minor child, or legal charge as indicated above. I understand that I may revoke this consent to release confidential information at any time with written consent, but that it will not affect any communication prior to notification of cancellation **This authorization does not serve as consent to release documents.**
Unless I revoke this authorization, this authorization shall remain in effect for one (1) year.

Patient's Signature (or legal guardian, if applicable) **X** _____	Date _____
Do you have a plan in case you are unable to make your own healthcare decisions? ☐ Y ☐ N	Social Security Number - -

Consent to Receive Text and/or Email Messages

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, and/or to provide general health reminder/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Cherokee Health Systems.
By initialing below, I consent to receive text messages from Cherokee Health Systems at my cell phone and any number forwarded or transferred to that number to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/health information unless I request a change in writing (see revocation below).

Patient Initials **X**_____

The **cell phone** number I authorize to receive text messages and the **email address** I authorize to receive email messages for appointment reminders and/or general health reminders/information are:

Cell Phone Number:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **text messaging**. Patient/Patient Representative Signature:
Email Address:		**Revocation Use Only** I hereby revoke my request to receive any future appointment reminders and general health information via **email**. Patient/Patient Representative Signature:

Patient's Name: *First* *Last*	Date of Birth

Financial Information

As a patient of Cherokee Health Systems, you are responsible for the payment of all fees associated with your care. However, we believe that money, or a lack of money, should never keep you from getting the care you need so all CHS services are available on an "ability to pay" basis. This means your income and family size will determine the amount you are asked to pay. By signing below, you agree to provide us with accurate information, now and in the future, and that you will attempt to pay your fees on the day you get your services. You may also choose to decline providing your financial information to us. However, by declining, you will not be eligible for income-based discounts, and will be responsible for payment of the full fees associated with your care.

Proof of Income is required for all discounts.: *Before a discount can be arranged, our funders require that you provide written proof of your total household income. You may use paycheck stubs for at least three consecutive pay periods, benefits check stubs, W-2 forms, a copy of your most recent federal income tax forms, or a copy of applications for any other agency benefits if they include household income (i.e., applications made at DHS, Helping Hands applications or cards, etc.*)

Patient's Signature (or legal guardian, if applicable) **X** _____	☐ I choose to decline sharing financial information

Household Income
(include all income from persons included in the count below):

Number of people living in your household:			
Sources of Income	**You**	**Others in your home**	**Total**
Wages from Employment			
Self-Employment			
Other Sources of Income	**You**	**Others in your home**	**Total**
Social Security			
Public Assistance			
Pensions			
Rental Income			
Child Support/Alimony			
Other (specify)			
		Grand Total:	

Authorization for Insurance Billing/Release of Information

Health insurance policies may cover a portion of the fees and CHS staff will assist you in making claims. It is expected that you will inform us of changes in your family status or health insurance coverage. Please fill in the name of your insurance company(s), and sign below.

By signing below, I authorize Cherokee Health Systems to assist me in obtaining third party benefits, to file benefit claims on my behalf, and to release any information necessary for the processing of my claim(s) to any of the insurance companies or third-party benefit agents listed below. I understand that such information may include diagnosis, dates of service, types of treatment, results of evaluations/assessments, actual progress notes, and other information about services received. This release shall remain in effect until all claims filed on my behalf have been processed.

I authorize and request direct payment of my health insurance benefits to Cherokee Health Systems. This authorization shall apply to all covered health services that I receive at the Center. If requested, I have been provided with a copy of the fee scale.

Guarantor Name		**Relation to Patient**		
Guarantor Contact Number		**Guarantor SSN & DOB**	**SSN:**	**Birthdate:**
Primary Insurance Name:		**Primary** Insurance ID#		
Secondary Insurance Name:		**Secondary** Insurance ID#		
Tertiary Insurance Name		**Tertiary** Insurance ID#		

Patient's Signature (or legal guardian, if applicable) **X** _____	Date _____
Witness _____	Date _____

Cherokee Health Systems
Together...Enhancing Life

Date of Visit:	
Account #:	

ADULT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**Date of Birth:**

Birthplace: (City & State) Education: (Grades or Degree) Occupation: Employer:

Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Are you currently receiving disability benefits? __ Yes __No Reason for Disability? _____

Previous or Referring Doctor:

List other Doctors you are seeing & their specialty:

IMMUNIZATIONS AND DATES

☐ Hepatitis B – Date:_____ ☐ Tetanus – Date:_____ ☐ TB Test – Date:_____ ☐ TB Positive or ☐ TB Negative

☐ Meningitis – Date:_____ ☐ Pneumonia – Date:_____ ☐ Flu – Date:_____ ☐ Zostavax – Date:_____

SURGERIES and HOSPITILIZATIONS:

Year:	Type of **Surgery** and Reason for Surgery:	Hospital Name:
Year:	Type of **Hospitalization for Illnesses** (Include Reason)	Hospital Name:
Year:	Type of **Psychiatric Admissions** & Reason for Admission (Include Substance Abuse Treatment)	Hospital Name:

ADULT FAMILY HEALTH HISTORY

If any family member has had health problems, please check the appropriate box.

☐ **PATIENT IS ADOPTED**

Relation	Alzheimers	Asthma	Alcohol Abuse	Bipolar	Drug Abuse	Blood Disease	Heart Disease	Stroke	Depression	Developmental Delay	Diabetes	High Cholesterol	High Blood Pressure	Mental Illness	Migraines	Over Weight	Blood Vessel Disease	Kidney Disease	Seizure Disorder	Cancer ____	Cancer ____	Other ____	Other ____	If deceased, list age & cause of death
Mother																								
Maternal Grandmother																								
Maternal Grandfather																								
Father																								
Paternal Grandmother																								
Paternal Grandfather																								
Sister (Name)																								
Sister (Name)																								
Brother (Name)																								
Brother (Name)																								
Other (Name)																								
Other (Name)																								

PERSONAL HEALTH HABITS

Tobacco	Do you use tobacco? ☐ Yes ☐ No ☐ Former Use Number of years you have used tobacco: _____
	Type: ☐ Cigarettes – # packs/day_____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____
	Have you tried to quit? ☐ Yes ☐ No Year you quit using tobacco:_____
Alcohol	Do you drink alcohol? ☐ Yes ☐ No ☐ Former Use Type:_____ Amount: Daily____ Weekly____ Monthly_____
Caffeine	☐ None ☐ Chocolate/**Daily Amt**_____ ☐ Coffee/**Daily Amt**_____ ☐ Cola/**Daily Amt**_____ ☐ Tea/**Daily Amt**____
Drugs	Do you use drugs <u>other than</u> prescription medications? ☐ Yes ☐ No ☐ Past Use Type:_____ Amount: Daily____ Weekly____ Monthly_____

WOMEN ONLY

Age when periods started:____ History of any abnormal pap tests? ☐ Yes ☐ No Describe Abnormal Finding:_____		
Currently Pregnant? ☐ Yes ☐ No	Number of Pregnancies:____ Number of live births:____ Number of C-Sections: _____	Currently Nursing: ☐ Yes ☐ No
Using birth control? ☐ Yes ☐ No	If yes, list type of birth control:	
Have you had a hysterectomy? ☐ Yes ☐ No	Date:	Reason:
Date of menopause:	Date of last pap test:	Date of last mammogram:
Date of last bone density test:	Date of last colonoscopy:	
Name of gynecologist:		

MEN ONLY

Date of last rectal exam?	Date of last PSA screen?
Date of last colonoscopy?	

PAST MEDICAL HISTORY - ADULT

Please check any conditions that have been previously diagnosed	Check if you still have this condition	Age problem began	Specify type, if known
☐ Acid Reflux	☐		
☐ AIDS/HIV –List Type	☐		
☐ Allergies	☐		
☐ Alzheimer's	☐		
☐ Arthritis	☐		
☐ Asthma	☐		
☐ Blood Disease	☐		
☐ Blood Vessel Disease	☐		
☐ Cancer –List Type	☐		
☐ COPD	☐		
☐ Depression	☐		
☐ Diabetes	☐		
☐ Eye Disease	☐		
☐ Emphysema	☐		
☐ Heart Disease	☐		
☐ Hepatitis (A,B,C) –List Type	☐		
☐ High Blood Pressure	☐		
☐ High Cholesterol	☐		
☐ Kidney Disease	☐		
☐ Mental Illness	☐		
☐ Migraines	☐		
☐ Obesity	☐		
☐ Respiratory Disease	☐		
☐ Sexually Transmitted Disease	☐		
☐ Seizure Disorder	☐		
☐ Stroke	☐		
☐ Substance Abuse –List Type	☐		
☐ Thyroid Disorder –List Type	☐		

PLEASE LIST ANY OTHER CONDITIONS OR IMPORTANT HEALTH INFORMATION:

NAME:_____ DATE OF BIRTH:_____ TODAY'S DATE:_____

PLEASE LIST ALL MEDICATIONS PATIENT IS CURRENTLY TAKING

(Include any medications swallowed, injected, inhaled or applied to the skin. Also list any vitamins or herbs that may be taken.)

Current Medication Name:	**Dose:**	**How often is the medication taken:**
Previous Medication Name:	**Dose:**	**How Often was the medication taken:**
(Other Medications taken in the **last 6 months** (not listed above) including over-the-counter medications.)		

DRUG/FOOD ALLERGIES	
Name of Drug/Food:	Type of Reaction from Drug/Food: