COMC

MEDICAL · BEHAVIORAL · DENTAL

Your Health......Our Mission.

Patient's Name: ______________________

Dear Parent/Guardian:

Your school District has partnered with Central Ozarks Dental Center to bring its NEW mobile dental unit to your school this year! COMC is a local non-profit organization that has worked to meet the health care needs of our community and the surrounding area since 1979. This program will provide any pre-registered child an opportunity to receive dental services at school during normal school hours. If your child already sees a local dentist, we strongly recommend that they remain with that practice for any cleanings or other dental care they need.

We offer compreshensive dental care. Our services include: examinations, cleanings, X-rays, fillings, extractions, and some crowns. There may be some procedures that cannot be completed on the mobile unit and it may be necessary to refer those patients to another dentist. We will provide referral information if this is necessary.

COMC Mobile Unit is able to serve all children in your district, who complete registration information and make advance financial arrangements. If your child is on any of the Missouri Medicaid programs, he/she will still be seen at no additional cost to you. In addition, we accept dental insurance or self-pay patients. If your child is uninsured, COMC staff can work with the parent/guardian to get them approved for Missouri Medicaid. We also offer a sliding scale discount program for those who qualify. If you would like additional information about our sliding scale discount please contact our office, and we would be happy to help you with the process.

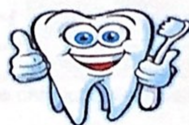
The dental unit is scheduled to be at: Stoutland School
During the weeks of: November 30th - December 4th

Parents, please complete the registration form and return it to school by: **November 9, 2020** in order for your child to be seen. We look forward to working with you and your child!

If you have any questions about our services, please contact Kelly Birdsong at kbirdsong@centralozarks.org or call 573-836-7061.

We look forward to rolling out our NEW mobile dental unit and being able to provide all dental services at our partnered schools. We can't wait to give the children a bright new smile!

Sincerely,
Kelly Birdsong
COMC School Service Coordinator



Circle of Care: Please list names of **ALL** providers who are treating you. including - Behavioral Health. Dentists and Specialists		
Name:	**Specialty:**	**Phone:**
1.		
2.		
3.		

Ethnicity

☐	Hispanic or Latino
☐	Not Hispanic
☐	Unreported /Refused to Report Ethnicity

Race

☐	Asian
☐	Native Hawaiian
☐	Other Pacific Islander
☐	Black/African American
☐	American Indian/ Alaska Native
☐	White (not Hispanic or Latino)
☐	More than one race
☐	Not Reported / Refuse to Report

Primary Language

☐	English
☐	Spanish
☐	Russian
☐	Ukrainian
☐	Other Please Specify:

How did you hear about us?

☐	Newspaper/TV/Radio Ad
☐	Website
☐	Special Event
☐	Employee
☐	Other Organization
☐	Friend
☐	Other

Do you identify yourself as:

☐	Straight (not lesbian or gay)
☐	Lesbian or gay
☐	Bisexual
☐	Something else
☐	Don't know
☐	Chose not to disclose
☐	Other

Education

☐	Current Student?
☐	Full Time
☐	Part Time

Highest Level of Education

☐	Not yet in school
☐	Pre-School Kindergarten
☐	Grade School
☐	Middle School
☐	High School
☐	High School Degree/ GED
☐	Did not complete High School
☐	Technical Trade School
☐	College
☐	College Graduate

COMC is my primary medical home?

☐	Yes
☐	No

What is your current gender identity?

☐	Female
☐	Male
☐	Transgender Male Female-to-Male
☐	Transgender Female Male-to-Female
☐	Gender queer, neither exclusively male nor female
☐	Other
☐	Chose not to disclose

Employment Status

☐	Full Time/ Part Time
☐	Migrant Worker
☐	Not a Migrant Worker
☐	Seasonal

Housing

☐Homeless

☐Doubling Up ☐Shelter
☐Other ☐Street
☐Transitional ☐Unknown

☐Public Housing-HUD
☐ Permanent Supportive Housing (PSH)

Are you a veteran?

☐	Yes
☐	No

I am using COMC today for an urgent care need?

☐	Yes
☐	No

What sex were you assigned at birth on your original birth certificate?

☐	Female
☐	Male
☐	Chose not to disclose

All requested information is for statistical purposes only and is necessary for receipt of federal grants to provide services.

COMC

MEDICAL · BEHAVIORAL · DENTAL

Your Health......Our Mission.

Patient Name: ______________________________ **Date of Birth:** ____________

- Are you under the care of a physician now? □Yes □No If yes, please list the physician's name and name of medical clinic: ______________________________
- Have you ever been hospitalized or had a major operation? □Yes □No If yes, please list surgeries: ______________________________
- Have you ever had a serious head or neck injury? □Yes □No If yes, please explain: ____________
- Have you ever had any abnormal bleeding, associated with previous extractions or surgery? □Yes □No If yes, please explain: ______________________________
- Are you taking medication, pills or drugs? □Yes □No **If yes, please list on following page.**
- Have you ever taken Fosamax, Boniva, Actonel, Zometa or any other medication containing biosphosphonates? □Yes □No If yes, please explain: ______________________________
- Do you use controlled substances? □Yes □No If yes, please list______________________________
- Do you use tobacco? □Yes □No If yes, how long: ____________ Packs per day:____________

Do you have, or have you had any of the following diseases/conditions?

AIDS/HIV Positive	□Yes □No	COPD	□Yes □No	Hemophilia	□Yes □No	Radiation Treatment	□Yes □No
Alzheimer's	□Yes □No	Cortisone Medication	□Yes □No	Hepatitis A	□Yes □No	Recent Weight Loss	□Yes □No
Anaphylaxis	□Yes □No	Diabetes	□Yes □No	Hepatitis B/C	□Yes □No	Renal Dialysis	□Yes □No
Anemia	□Yes □No	Drug Addiction	□Yes □No	Herpes	□Yes □No	Rheumatic Fever	□Yes □No
Angina	□Yes □No	Easily Winded	□Yes □No	High Blood Pressure	□Yes □No	Rheumatism	□Yes □No
Arthritis /Gout	□Yes □No	Emphysema	□Yes □No	High Cholesterol	□Yes □No	Scarlet Fever	□Yes □No
Artificial Heart Valve	□Yes □No	Epilepsy/Seizures	□Yes □No	Hives/Rash	□Yes □No	Shingles	□Yes □No
Asthma	□Yes □No	Excessive Bleeding	□Yes □No	Hypoglycemia	□Yes □No	Sickle Cell Disease	□Yes □No
Autism/Cognitive Disorder	□Yes □No	Excessive Thirst	□Yes □No	Irregular Heartbeat	□Yes □No	Sinus Trouble	□Yes □No
Blood Disease	□Yes □No	Fainting/Dizziness	□Yes □No	Kidney Problems	□Yes □No	Spina Bifida	□Yes □No
Blood Transfusion	□Yes □No	Frequent Cough	□Yes □No	Leukemia	□Yes □No	Stomach/Intestinal Disease	□Yes □No
Breathing Problems	□Yes □No	Frequent Diarrhea	□Yes □No	Liver Disease	□Yes □No	Stroke	□Yes □No
Bruise Easily	□Yes □No	Frequent Headaches	□Yes □No	Low Blood Pressure	□Yes □No	Swelling of Limbs	□Yes □No
Cancer	□Yes □No	Genital Herpes	□Yes □No	Lung Disease	□Yes □No	Thyroid Disease	□Yes □No
Chemotherapy	□Yes □No	Glaucoma	□Yes □No	Mitral Valve Prolapse	□Yes □No	Tonsillitis	□Yes □No
Chest Pain	□Yes □No	Heart Attack/Failure	□Yes □No	Osteoporosis	□Yes □No	Tuberculosis	□Yes □No
Cold Sores/Fever Blisters	□Yes □No	Heart Murmur	□Yes □No	Pain in Jaw Joints	□Yes □No	Tumors/Growths	□Yes □No
Congenital Heart Disorder	□Yes □No	Heart Pacemaker	□Yes □No	Parathyroid Disease	□Yes □No	Ulcers	□Yes □No
Convulsions	□Yes □No	Heart Trouble/Disease	□Yes □No	Psychiatric Care	□Yes □No	Venereal Disease	□Yes □No
Any other serious illnesses not listed? ____________						Yellow Jaundice	□Yes □No

All patients, are you allergic to any of the following:

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Sulfa Drugs □ Local Anesthetics
□ Nut Allergy □ Milk Protein □ Tylenol □ Ibuprofen/NSAIDS □ Latex □ Other? ____________

Women, are you?

Pregnant/Trying to get pregnant? □Yes □No Nursing? □Yes □No Taking oral contraceptives? □Yes □No
If pregnant, how many weeks? ____________ Due Date: ____________

Signature of Patient, Parent or Guardian:______________________________

Relationship to Patient: ______________________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I am aware that it is my responsibility to inform the dental office of any changes in medical status.

Dental Consent to Treat Patient without Parent/Legal Guardian Present

Authorization

I have the legal right to preauthorize Central Ozarks Community Center's Mobile Unit and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but is not limited to: dental examination, prophylaxis (cleaning), fluoride treatment, x-rays, sealants, and the creation of a treatment plan.

I, ____(please print parent/guardian name) request and authorize Central Ozarks Community Center and its personnel to deliver routine dental care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor:

Child's name:_______________________________________ Date of Birth: ______________

Limitations

Identify any specific limitations on the kinds of dental services/treatments for which this authorization is given: ____

____.

I affirm that I am either: The parent of the minor child in my legal custody; or a minor who has been lawfully married; or a minor parent or legal custodian of the minor child; or an adult standing in loco parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo; or a guardian of the minor for his ward; or a relative caregiver of the minor child as provided for in section 431.058 RSMo; or an adult eighteen years or older for myself.

_________________________________ _________________________________
Parent/Legal Guardian Name (print) Relationship to patient

_________________________________ _________________________________
Parent/Legal Guardian Signature Date

Treatment will require signatures on Consent Form on the next three pages.
This consent form will remain in effect for the 2020-2021 school year.

Informed Consent for Composite (Tooth-colored) Fillings

I understand that the treatment of dentition (teeth) involving the placement of composite, resin fillings which may be more aesthetic in appearance than some of the conventional materials that have been traditionally used (such as amalgam or gold), may entail certain risks. There is a possibility of failure to achieve the desired or expected results. I agree to assume those risks those that may occur, even if care and diligence is exercised by COMC Mobile Dental Unit dentist, in rendering treatment. These risks include possible unsuccessful results and/or failure of the filling associated with, but not limited to the following: Sensitivity, Risk of Fracture, Necessity for Root Canal Therapy, Possible need to perform direct or indirect Pulp Car, Injury to the Nerves, Tooth coloration that may not exactly match tooth color and color that may change over time, Breakage, Dislodgement, or Bond Failure.

Informed Consent

I understand that it is my responsibility to notify COMC dentist should any undue or unexpected problems occur, or if I experience any problems related or the treatment rendered, or the services performed. I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, that may be associated with any phase of this treatment in hope of obtaining the desired outcome. By signing this document, I authorize COMC Mobile dentist and/or his associates to render any services deemed necessary or advisable in the treatment of my dental condition, including prescribing and the administration of any medically necessary anesthetic agents and/or medications.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

______________________________ ______________
Parent of Guardian Signature Date

______________________________ ______________
Reviewed by Date

Informed Consent for Extraction
(Removal of Tooth)

I understand that there may be alternatives to the extraction of teeth. After reviewing the various options presented to me by the dentist with Central Ozarks Community Center, I have agreed to allow the extraction of tooth/teeth that need to be removed. I understand that there are various normal complications that can occur despite all efforts to the contrary as a result of the extraction(s) which include, but are not limited to: Dry Socket, Infection bleeding and/or bruising which may be prolonged, Swelling, Injury to adjacent teeth or fillings, Unusual reaction to medications given or prescribed, Sinus involvement (which my require surgical repair), Injury to the nerves of the lower lip and tongue causing numbness (which could possibly be permanent), Pain or injury of the temporomandibular joint (TMJ), Including broken jaw.

I understand that a perfect result cannot be promises or guaranteed. If any unforeseen conditions arise during the procedure, I request and authorize COMC dentist to do whatever he/she deems advisable to correct the condition.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

_______________________________________ ____________________

Parent of Guardian Signature Date

_______________________________________ ____________________

Reviewed by Date

Consent for Nitrous Oxide
(Laughing Gas)

Nitrous Oxide/Oxygen Inhalation is a mild form of conscious sedation used to calm an anxious patient. It is a colorless, odorless gas that is administered through a small mask placed over the nose. Oxygen is used after the procedure to flush the nitrous oxide out of the patient's system and minimize the effects of the gas.

Benefits of Nitrous Oxide: Relief of Anxiety, Pain Control, Relief of Gagging, and Reduction of Overall Stress.

Nitrous Oxide Risks: Nausea and Vomiting, Excessive Perspiration, Temporary Inability to Perceive One's Spatial Orientation, and Numbness and/or Tingling.

Acknowledgement

I acknowledge that all questions I have asked concerning Nitrous Oxide have been answered to my satisfaction. I understand the information that has been provided to me and wish for my child/myself to receive Nitrous Oxide.

I have provided an accurate and completed medical and personal history as possible, including antibiotics, drugs, herbal supplements, or other medications (prescription or non-prescription) I am currently taking as well as those to which I am allergic.

I affirm that I am either: The parent of the minor child in my legal custody; or A minor who has been lawfully married, or A minor parent of legal custodian of the minor child, or An adult standing in loc parentis, whether serving formally or not, for the minor charge in case of emergency as defined in section 431.063 RSMo, or A guardian of the minor for his ward, or A relative caregiver of the minor child as provided for in section 431.058 RSMo, or An adult eighteen years or older for myself.

____ ________________________

Parent of Guardian Signature Date

____ ________________________

Reviewed by Date

HIPAA Release and Accompaniment of Minor

I hereby authorize the below listed individuals' access to above listed minor's health information (if this section is not completed, we will only use your medical record for treatment, payment and healthcare purposes). We will not be able to release your medical information to family members or friends unless they are listed by name below.

Please indicate below if you additionally authorize a listed individual to accompany AND make medical/dental decisions regarding treatment at appointments of the above listed minor patient. Furthermore, I acknowledge that this consent will remain in effect unless I notify the dental clinic of changes.

Authorized Individual	Relationship to child	May bring minor to appointment AND make medical/dental decisions
		___Yes ___No
		___Yes ___No
		___Yes ___No
		___Yes ___No
		___Yes ___No

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. Our Notice of Privacy Practices is attached. We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I________________________________, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

I attest that to the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health and unlawful. It is my responsibility to inform the dental office of any changes related to information provided in this packet.

____

Signature of the Patient, Guardian, or Power of Attorney Date

____

Relationship to patient (if applicable) Date

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PHOTO RELEASE FORM

MINOR CHILD'S NAME ____

PARENT(S) ____

ADDRESS ____

PHONE ______________________ OR ______________________

EMAIL ____

_______ I DO give permission for my child's picture to be used by COMC on their Facebook account or any other publication in conjunction with Central Ozarks Medical Centers, with the understanding that his/her name will not be used with the photo nor will he/she be identified in any other way.

_______ I DO NOT give permission for my child's picture to be used by COMC

____

Parent/Legal Guardian Name (print)

____

Parent/Legal Guardian Signature

____

Date

allowed to use or disclose your health information for marketing purposes or sell your health information without your authorization. Other uses and disclosures of your health information not described in this Notice of Privacy Practices or applicable laws will require your written authorization. If you choose to permit us to use or disclose your health information, you can revoke that authorization by informing us of your decision in writing. If you revoke your authorization, we will no longer use or disclose your health information as set forth in the authorization. However, any use or disclosure of your health information made in reliance on your authorization before it was revoked, will not be affected by the revocation.

Your rights regarding your health information: In most cases, **you may make a written request to look at, or get a copy of your health information.** If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you have the right to have that denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of that review. **If your health information is maintained in electronic format, you have the right to request an electronic copy of your health information.** If your health information is not readily producible in the format you request, it will be provided either in our standard electronic format or as a paper document. We may charge you a reasonable cost based fee for the labor associated with transmitting electronic health information. If you feel your health information is incorrect or incomplete, **you have the right to request that we amend your information**. You must submit a written request providing your reason for requesting the amendment to the Privacy Officer. Your request to amend your health information may be denied if it was not created by us; if it is not part of the information maintained by us; or if we determine that the information is correct. You may submit a written appeal if you disagree. Your request for amendment will be included as a part of your health information. **You have the right to receive a list of certain disclosures we made of your health information**, for a period of time up to six years prior to the date of your request. The first list you request in a 12-month period is free. If you make more requests during that time, you may be charged our cost to produce the list. We will tell you about the cost before you are charged. **You have the right to a paper copy of this notice.** You may ask us to give you a copy of this notice at any time. **You have the right to request that your health information be given to you in a confidential manner**. You have the right to request that we communicate with you in a certain way or at a certain location, such as by mail or at your workplace. Any such request must be made in writing to the Privacy Officer. We will accommodate reasonable requests. **You have a right to ask that we not disclose your health information to your health plan if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.** Such restricted disclosure must pertain solely to a healthcare item or service for which you, or someone on your behalf, have paid us in full. **You may request, in writing, that we not use or disclose your health information** for treatment, payment or healthcare operations; or to persons involved in your care; when required by law; or in an emergency. All written requests or appeals should be submitted to our Compliance Office listed at the end of this notice. We are not required to agree with the requested restrictions. **You have the right to be notified if there is an unauthorized use or disclosure of your unsecured protected health information unless we determine that there is a low probability that your information has been compromised.**

Complaints:

If you believe that your privacy rights may have been violated, you may contact our Privacy Officer, Amy McNulty, at 573 836-7112 or by email at amcnulty@centralozarks.org. You may write us at Central Ozarks Medical Center Attn: Amy McNulty PO Box 777, Richland, MO 65556. You may also contact Missouri Department of Health, Bureau of Health Facility Regulation: 1-573-751-6303 and/or the State Attorney General's Office Consumer Hot Line: 1-800-392-8222. You may file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html The Office of Corporate Compliance can provide the mailing address. We will not retaliate against you for filing a complaint. If we change our policies regarding our use and/or disclosure of your protected health information, we will change our Notice of Privacy Practices and make the revised notice available to you on our website and our practice locations. You may access our website at: https://www.centralozarks.org. You may also request a paper copy of the current Notice of Privacy Practices at any time.

Notice of Privacy Practices

Please tear this page off and retain for your records

This notice describes how medical information about you can be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please contact our Privacy Officer at phone number (573) 836-7112 or amcnulty@centralozarks.org.

Who will follow this notice?

The list below tells you who will follow the outlined practice for keeping your medical record private. All Central Ozarks Medical Center Medical and Dental Clinics (COMC). Any COMC health care professional that treats you at any of our locations. All COMC employees, temporary or contract staff, students and volunteers.

What is this Notice?

We are required by law to maintain the privacy of your protected health information. We are also required by law to give you this notice of our legal duties and privacy practices regarding your health information. We are required to notify you if there is a breach of your unsecured protected health information. We are required to follow the terms of the current Notice of Privacy Practices.

We may use and disclose your health information for:

Treatment: We may use and disclose health information for your medical treatment and services. **Payment**: We may use and disclose health information to bill for and receive payment for the services provided to you. **Health Care Operations**: We may use and disclose health information for purposes of health care operations. **Appointment Reminders**: To remind you that you have an appointment scheduled with us. **Treatment Alternatives:** To inform you of treatment options available to you. **As required by Law**: When required to do so by applicable law. **To prevent a Serious Threat to Health or Safety**: To prevent a serious threat to your health and safety or the health and safety of others. **Individuals Involved in your Care:** Unless you object, to friends, family members or others involved in your medical care or who may be helping pay for your care. **Organ and Tissue Donation:** Organ or tissue donation to organizations that handle organ procurement and transplant. **Decedents:** Health records for patients deceased 50 or more years are no longer considered Protected Health Information. **Genetic Information:** Genetic Information is considered Protected Health Information, which may be disclosed with authorization but cannot be used by health plans for underwriting purposes. **Military and Veterans:** If you are a member of the armed forces, as required by military command authority. **Worker's Compensation:** For worker's compensation purposes or similar programs providing benefits for work related injury or illness. **Public Health Activities:** For public health activities such as preventing or control of disease, reporting births and deaths, and reporting child abuse and neglect. **Health Oversight Activities**: To governmental agencies and boards as authorized by law such as licensing and compliance purposes. **Breach Notification:** Uses or disclosures of PHI that are not permissible are now presumed to be a Breach, unless it can be demonstrated a "low probability" exists that your PHI has been compromised or that an exception applies. **Disaster Relief:** Unless you object, to disaster relief organizations to coordinate your care or notify family and friends of your location or condition following a disaster. **Lawsuits and Disputes:** In response to a warrant, court order, or other lawful process. **Law Enforcement:** Pursuant to process and as otherwise required by law. **Coroners, Medical Examiners, Funeral Directors**: As necessary to determine the cause of death or to perform their duties. **National Security and Intelligence Activities**: To authorized federal officials for intelligence and other national security activities as authorized by law. **Protective Services for the President and Others**: To federal officials to provide protection to the President and other authorized persons, or conduct special investigations. **Inmates or Individuals in Custody:** If you are an inmate or in the custody of law enforcement, we may disclose to the correctional institution or law enforcement official as necessary to provide you with health care, to protect the health and safety of you and others, or for the safety and security of the correctional institution. **Research Studies and Clinical Trials:** Authorizations may be combined in the research context subject to certain requirements, and authorizations for future research are also permitted. **Business Associates:** Business Associates are directly liable for violations of the HIPAA/HITECH Act. Subcontractors of a business associate that create, receive, maintain or transmit PHI on behalf of the business associate are likewise HIPAA business associates, and subject to the same requirements that the first business associate is subject to. **Fundraising:** For raising funds. You may opt out of receiving fundraising communications at any time. **Other disclosures:** With certain exceptions, we are not allowed to use or disclose psychotherapy notes without your authorization. We are also not

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Central Ozarks Medical Center
If you need help filling out this form, please let us know.

PEDIATRIC DENTAL REGISTRATION (SCHOOL BASED)

(Please Print)

Today's Date:	COMC Medical Provider:	COMC Dental Provider:

PATIENT INFORMATION

Patient's First Name:	Middle Initial:	Last Name:	Social Security Number:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	State:	Zip Code:

Mailing Address: ❑ Same as above	If homeless, please state homeless Status: ❑ Doubling Up ❑ Homeless ❑ Homeless Shelter ❑ Other: ______

Email Address:	Home Phone Number: ( )	Cell Phone Number: ( )	Work Phone Number: ( )

May we text you for appointment reminders: ❑Yes ❑ No	Preferred Pharmacy:	Preferred method of contact for reminder calls and messages: □ Cell □ Home □ Work

❑ Parent/Guardian **OR** ❑ Spouse Information: Name:	Address: ❑ Same as above	Primary Phone Number: ( )

Does the patient have any problems with: ❑ Vision ❑ Hearing ❑ Reading ❑ Speaking Explain:

MEDICAL INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Primary Phone Number: ( )

Occupation:	Employer:	Employer Phone Number: ( )

Patients relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Step Child ❑ Other

Primary Medical Insurance:	❑ Medicare ❑ Medicaid	❑ Blue Cross Blue Shield ❑ Cigna		❑ Other:	
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #:	Group #:	Co-Payment: $

Name of **Secondary Medical Insurance** (if applicable):	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Policy #: Group #:

DENTAL INSURANCE INFORMATION

Primary Dental Insurance:	Subscriber's Name:		Subscriber's SSN:
	Policy #:	Group #:	Subscriber's Birth Date: / /

Dental Claims Address (on back of card): ______

Home Room Teacher: ______ **Grade student is in:** ______

Emergency Contact Name: ______ **Phone #:** ______

The above information is true to the best of my knowledge. I authorize assignment of benefits for services received to be paid directly to Central Ozarks Medical Center. I understand that I am financially responsible for any balance. I also authorize COMC or my insurance company to release any information required to process my claims.

Signature: ______ Date: ______