SOUTHERN COOS HOSPITAL & HEALTH CENTER

Quality Healthcare With a Personal Touch

Patient Registration Form

Patient Demographic Information

Patient Name: (Last, First, M.I.)				**Preferred Name:**
Date of Birth:	**Sex at Birth:** ☐ Male ☐ Female	**Mailing Address**	**City**	**State** **Zip**
Home Phone:	**Cell Phone:**	**Physical Address**	**City**	**State** **Zip**
Social Security Number:		**Email Address:**		
Driver's License # and State:		**Preferred Pharmacy and Location:**		**Religion:**

Patient Martial Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed
☐ Domestic partner ☐ Separated

Do you have an Advance Directive, POLST, Living Will, or Power of Attorney? Yes ☐ No ☐ **Type:**

Ethnicity:
☐ Hispanic/Latino/Latina
☐ Non-Hispanic, Latino, Latina

Race:
☐ White ☐ Asian ☐ Native American ☐ Alaskan Native
☐ African American ☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race ☐ Other:_____

Employment Status:
☐ Employed ☐ Unemployed ☐ Retired

Employer Name:

Patient Emergency Contact Information

Emergency Contact Name:	**Relationship to Patient:**	**Phone Number:**

Responsible Party Information

Responsible Party Name:	**Relationship to Patient:**	**Responsible Party Social Security #:**
Mailing Address **City** **State** **Zip**		**Phone Number:**

Are you self-pay or uninsured?
☐ Yes ☐ No If yes, skip to Health History Form

Primary Insurance Company:	**Policy/Member ID #:**	**Policy Group #:**
Policy Holder Name: ☐ Same as above	**Policy Holder DOB:** ☐ Same as above	**Policy Holder Social Security #:** ☐ Same as above
Secondary Insurance Company:	**Policy/Member ID #:**	**Policy Group #:**
Policy Holder Name: ☐ Same as above	**Policy Holder DOB:** ☐ Same as above	**Policy Holder Social Security #:** ☐ Same as above

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Health History – Adult

Patient Name:_____ **Date of Birth:**_____ **Today's Date**_____

Current Medications: List all prescriptions, non-prescriptions, and over the counter (OTC) medications that you currently take. Please include any herbal and/or nutritional supplements, inhalers, eye drops, ointments, etc.		
Medication	**Dose**	**Frequency**

Patient Allergy Information			
Are you allergic to medications, iodine, shellfish, food, tape, or latex? ☐ **Yes** ☐ **No**			
Allergy	**Reaction**	**Allergy**	**Reaction**
☐ **No Known Allergies**			

Preventive History			
Screening	**Date**	**Screening**	**Date**
Colonoscopy		Mammogram	
Cologuard		Pap Smear	
FIT Test		DEXA/Bone Density Scan	
Influenza Vaccine		Pneumonia Vaccine	
COVID-19 Vaccine		Shingles Vaccine	

Past Surgical History			
Date	**Operation/Procedure**	**Reason**	**Hospital/Facility**

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Significant Family History: Check any family member who has suffered or experienced any of the following conditions:							
Condition	**Mother**	**Father**	**Sister(s)**	**Brother (s)**	**Child(ren)**	**Grandmother**	**Grandfather**
Arthritis						□ Maternal □ Paternal	□ Maternal □ Paternal
Cancer						□ Maternal □ Paternal	□ Maternal □ Paternal
Depression						□ Maternal □ Paternal	□ Maternal □ Paternal
Diabetes						□ Maternal □ Paternal	□ Maternal □ Paternal
Heart Disease						□ Maternal □ Paternal	□ Maternal □ Paternal
High Blood Pressure						□ Maternal □ Paternal	□ Maternal □ Paternal
Kidney Disease						□ Maternal □ Paternal	□ Maternal □ Paternal
Stroke/TIA						□ Maternal □ Paternal	□ Maternal □ Paternal
Other:						□ Maternal □ Paternal	□ Maternal □ Paternal

Personal Medical History Please check all that apply in box to the right							
Abuse (physical)		**Cataracts**		Pacemaker		COPD/Emphysema	
Abuse (sexually)		**Crohn's disease**		Abnormal heart rhythm		Chronic Bronchitis	
HIV/AIDS		**Colon Polyp**		Atrial Fibrillation		Asthma	
Alcoholism		**Depression**		**Hepatitis**		**Mental illness**	
Anemia		**Diabetes**		**Hernia**		**Multiple sclerosis**	
Anorexia/bulimia		**Epilepsy/seizures**		**Herpes**		**Pneumonia**	
Bladder problems		**Gall stones**		**High blood pressure**		**Sleep Apnea**	
Blood transfusion		**GERD**		**High cholesterol**		**STD/STI**	
Bleeding disorders		**Glaucoma**		**Irregular periods**		**Stomach ulcers**	
Blood clots		**Headaches**		**Kidney problems**		**Stroke**	
Breast lump		**Heart disease**		**Liver disease**		**Thyroid problems**	
Cancer		Coronary artery disease		**Lung disease**		**Tuberculosis**	

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Social History Please circle or write the answer						
Exercise Routine:	None	Infrequently	Frequently	Daily		
Exercise Frequency:	Times per day:	Times per week:	Times per month:			
Smoking Status:	Every day smoker	Some day smoker	Former smoker	Never smoked		
# packs per day:	**# of years smoking:**	Cigarettes / Cigars / Pipes				
Smokeless Tobacco Status:	Chews tobacco	Snuff user	Former user	Never used		
# times used per day:	**# years used:**					
Electronic Cigarettes Status:	Every day smoker	Some day smoker	Former smoker	Never smoked		
# of years smoking:						
Substance Use:	Never	Rare	Occasional	Frequent	Addiction	Recovering Addiction
Usage Routes:	Oral	Smoking	Intranasal	Inhalation	Subcutaneous	Intravenous
Substance Used:	Cocaine	Methamphetamine	Heroin	Marijuana	Prescription Drug Abuse	
Frequency Used:	# Times Day	# Times Week	# Times Month			
Alcohol Use:	Never	Rare	Occasional	Frequent	Binge Drinker	In Recovery	Quit
Alcohol Type:	Beer	Wine	Liquor			
Frequency:	# Drinks per day	# Drinks per week	# Drinks per month			
Are you sexually active? Yes No						
Sexual Orientation:	Straight or heterosexual	Lesbian, Gay or Homosexual	Bisexual	Don't know	Chooses not to disclose	
Gender Identity:	Identifies as Male	Identifies as Female	Transgender Male: Female-to-Male	Transgender Woman: Male-to-Female	Genderqueer	Non-Binary

Women's Health History Please write or circle the answer			
Age Period Started:	**Do you have regular periods:** Yes No	**Abnormal bleeding:** Yes No	
Have you had an abnormal Pap Smear? Yes No	**If yes, type of follow-up:**		
Are you on birth control? Yes No	**If yes, what type?**		
Have you had a:	**Tubal ligation?** Yes No	**Hysterectomy?** Yes No	**Did they remove ovaries?** Yes No
# of Pregnancies:	**# of Live Births:**	**# of Miscarriages/Abortions:**	
Would you like to become pregnant in the next year?	Yes	No	Ok either way	Unsure

Southern Coos Hospital & Health Center
900 11th St. SE – Bandon, OR 97411
541-347-2426
southerncoos.org

TERMS AND CONDITIONS OF SERVICE

CONSENT TO HOSPITAL SERVICES: By signing below, the undersigned consents to the procedures and medical treatment that may be performed during this hospitalization or on an outpatient basis, including emergency services for treatment. This may include, but is not limited to, laboratory procedures, x-ray examinations, medical / surgical treatments or procedures, anesthesia, and hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

NURSING CARE: the hospital provides only general duty nursing care unless otherwise ordered by the physician or surgeon.

PHOTOGRAPHS: the hospital may take photographs of me for identification purposes. The hospital may take photographs of appropriate parts of my body in order to provide supporting documentation of my medical condition. Any photographs taken will be placed in and remain part of the medical record.

PRESCRIPTION HISTORY: I authorize Southern Coos Hospital & Health Center and its affiliated providers to view my external prescription history via electronic exchange. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

PHYSICIAN SERVICES AND BILLINGS: The patient will be under the care and supervision of his or her attending physician (or the hospitalist) and it will be the responsibility of the hospital and its staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent when required for medical or surgical treatment, special diagnostic or therapeutic procedures and hospital services rendered to the patient under the general and special instructions of the physician.

FINANCIAL AGREEMENT: I agree to pay Southern Coos Hospital & Health Center (SCH) for services received. I understand I am financially responsible to the hospital for charges not covered by my insurance or other payers, which may include a deductible and co-payment that are expected to be paid at the time of service. If insurance payment is not received, the balance in full becomes my responsibility. I agree to promptly pay any charges not immediately (within 30 days) covered by insurance(s). If this account is referred to collection, I agree to pay reasonable attorney fees and collection expenses, including any accrued interest.

LATE PAYMENT FEES: The hospital computes its late payment fees at an annual periodic rate of 9% on unpaid balances commencing ninety (90) days from the date of self-pay billing. Such fees may be added to each subsequent monthly statement. The account balances may be prepaid in full at any time without penalty.

ASSIGNMENT OF INSURANCE BENEFITS: I assign insurance benefits to the hospital. I transfer my right to payments due to me from the insurance to the hospital.

INSURANCE: PRE-CERTIFICATION/AUTHORIZATION: Many insurance companies require that hospital services, Inpatient or Outpatient, are pre-certified and/or authorized in advance. Some insurance companies require the INSURED to notify the insurance carrier to obtain the pre-certification and/or authorization prior to admission (Inpatient, observation, outpatient or day/ambulatory surgery). Failure to do so may result in a reduction or rejection of benefits by your insurance. As a courtesy to our patients, SCH makes every attempt to ensure these requirements are met, as well as verify coverage; however,

this does not constitute a guarantee of payment. Please direct questions regarding these requirements to your insurance company's benefit representative.

RELEASE OF INFORMATION: By signing, the patient or their legal representative consents to the release of any information from the patient's medical record and billing record that may be needed by third party payers and agents of the hospital for payment of hospital and physician charges. The hospital will otherwise obtain specific written consent as required by state and federal law from the patient for release of information including HIV, alcohol and drug abuse obtained in the course of diagnosis and Information except in those circumstances when the hospital is permitted or required by law to release information for purposes of continuing medical care or medical emergency care. Patient consents to release medical records from this visit to their primary care provider.

HEALTH INFORMATION EXCHANGE: As part of your continuum of care, Southern Coos Hospital & Health Center participates in CommonWell, a service that allows participants to securely identify, send, and receive your accurate and approved medical information. This free service is offered so that your health information may be quickly and securely available to your doctors who participate in the CommonWell/Care Quality network. By signing below, you agree to allow your protected health information to be available to participants of CommonWell and to allow SCHHC to disclose information related to your visit to the CommonWell network. I understand that this authorization is revocable by me at any time if I provide a written, signed notice except to the extent that action has been taken on this release.

FOR MEDICARE BENEFICIARIES ONLY: I certify that the information given by me in applying for payment under Title XVIII for the social security act is correct. I authorize any holder of medical or other Information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf, I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

MEDICARE NON-COVERED SEVICES: Medicare will only pay for services determined to be reasonable and necessary under section 1862 (a) (1) of the Social Security Act. If Medicare determines that a particular service ls not reasonable and necessary, although it would otherwise be covered under the Medicare program standards, Medicare will deny payments for that service. Medicare does not pay for Outpatient oral medications, dental services, personal items, take-home prescriptions and/or personal telephone conferences.

PERSONAL VALUABLES: The hospital encourages patients to leave valuables at home or with a family member. The hospital maintains a safe for storing patient valuables during their stay. The hospital will be responsible ONLY for those items documented and committed to safekeeping.

TOBACCO-FREE POLICY: No Tobacco products may be used on district property.

I HAVE READ, FULLY UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS.

_____ _____

Printed Patient Name or Parent/Legal Guardian Name **Date**

_____ _____

Patient/Legal Representative Signature **Date**

SOUTHERN COOS HOSPITAL & HEALTH CENTER

900 11th St., SE
Bandon, OR 97411
(541) 347-2426

Permission to Verbally Discuss Protected Health Information with Family and Friends – Information Sheet

We have established a process that allows you to tell us who we may talk with about your health care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

Does this mean that you will not speak to anyone I haven't specifically named on the form?

No. If permitted by law, Southern Coos Hospital & Health Center may speak to other individuals involved in your care (or payment for that care).

How is the information on the form used?

Anytime your designated person calls on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an individual wants to share information with spouse or significant other
- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping a patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown below.

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, the patient must complete a separate Authorization form from Southern Coos Hospital & Health Center.

Where do I send the completed form or any changes?

Please send or fax the completed form or any changes to Southern Coos Hospital & Health Center (contact information is below).

Note: If you need to obtain copies of your health records, contact Health Information Management using the contact information below.

Southern Coos Hospital & Health Center
900 11th St SE
Bandon, OR 97411
(541) 347-2426
FAX: (541) 347-7324
medicalrecords@southerncoos.org

SOUTHERN COOS HOSPITAL & HEALTH CENTER

900 11th St., SE
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Permission to Verbally Discuss Protected Health Information with Family and Friends

Patient name	Date of birth	Medical record number, if known	
Patient street address	City	State	ZIP
Home phone	Work phone		

I give permission for Southern Coos Hospital & Health Center to VERBALLY share the information I have checked below, with the family, friends or others that I have identified below as being involved in my health care, care coordination or payment of my health care. This form does not authorize releasing copies of my records nor does it authorize the below named individuals to sign authorizations for treatment or payment of health care services.

Check all boxes that apply

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
  - ☐ Substance use disorder
  - ☐ Developmental disability
- ☐ Lab/test results (☐ check here to include HIV results)
- ☐ Billing and payment information
- ☐ Other (describe):

Southern Coos Hospital & Health Center has my permission to discuss the above information with the following family, friends and other people. This information is directly relevant to their involvement in my health care (or payment for that care).

1. Name: _____

   Relation to Patient: _____ Contact Number: _____

2. Name: _____

   Relation to Patient: _____ Contact Number: _____

I understand that in certain situations Southern Coos Hospital & Health Center may speak to other individuals who are involved in my care or payment of that care that may not be identified on this form, if permitted by law.

I understand that I have the right to revoke my permission at any time except where Southern Coos Hospital & Health Center has already made disclosures in accordance with this request. **I understand this permission remains in effect until the time I revoke it in writing.**

Signature of Patient/Authorized Representative: _____

Date Signed: _____

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Southern Coos Hospital & Health Center

Privacy Practices Notification

I, _____ have been offered for review or received written notification of the privacy practices in place at Southern Coos Hospital & Health Center.

_____ _____

Signature of Patient or Representative Medical Record #

_____

Date

If patient / representative declines to sign, the employee must complete this section.

☐ "A GOOD FAITH EFFORT WAS MADE TO OBTAIN A SIGNATURE ON THIS FORM."

_____

Date

_____

Employee Signature

Southern Coos Hospital & Health Center
Patient Handbook Acknowledgement

I, _____ have received and had an opportunity to ask questions on the Welcome Packet.

_____

Signature of Patient or Representative

_____

Date

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Phone: (541) 347-2426
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Authorization for Use and Disclosure of Health Information

Where are the records being released from?

Facility Name:
Address:
City: State: Zip:
Phone: Fax:

Patient Information

Name: DOB:
Email:
Address: City: State: Zip:
Phone: Fax:

Records being released to:

Name: **Southern Coos Hospital & Health Center**
SECURE Email: **medicalrecords@southerncoos.org**
Address: **900 11th St SE** City: **Bandon** State: **Oregon** Zip: **97411**
Phone: **541-347-2426** Fax: **541-347-7324**

What would you like released? Check all that apply.

- ☐ Medical Records last 2 yrs (industry standard)
- ☐ Office/Clinic Notes
- ☐ Operative Reports
- ☐ ED / Inpatient Visit
- ☐ Lab/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ All Records
- ☐ Other: Dates: to

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- ☐ Drug/alcohol diagnosis, treatment, or referral Info
- ☐ Genetic Testing Information
- ☐ AIDS/HIV Information
- ☐ Mental Health Information

Purpose of Disclosure:

- ☐ Continuation of Care
- ☐ Transfer to New Physician

Patient's Signature

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time, by sending a written authorization to: Southern Coos Hospital & Health Center, c/o Medical Records, 900 11th Street, SE, Bandon, OR 97411. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. This authorization will expire in 6 months from the date sign.

Patient's Signature: Date:
Relationship to Patient:

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Phone: (541) 347-2426
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Facility Name:
Address:
City: State: Zip:
Phone: Fax:

Patient Information

Name: DOB:
Email:
Address: City: State: Zip:
Phone: Fax:

Records being released to:

Name: **Southern Coos Hospital & Health Center**
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Patient's Signature: Date:
Relationship to Patient: