Patient Packet

Please fill out and return to ODHC
prior to your appointment

ODHC Mankato
Medical, Behavioral Health & Dental
309 Holly Lane
Mankato, MN 556001
Tel: (507) 388-2120

ODHC Jordan
Dental
115 Broadway Street South #600
Jordan, MN 55352
Tel: (952) 492-6342

ODHC Clarkfield
Dental
1025 10th Avenue
Clarkfield, MN 56223
Tel: (320) 669-7564

THIS PAGE LEFT BLANK INTENTIONALLY

Patient Registration

Thank you for giving us the opportunity to serve you! To help us meet your needs, please fill out the registration form completely. All information is kept confidential. If you have any questions, we are happy to help!

*****IF THE PATIENT IS A MINOR OR HAS A GUARDIAN, the parent/guardian must complete all registration paperwork.**

PATIENT INFORMATION

Social Security # _____ (used **only** for insurance verification and statistics)

Patient's Last (Family) Name _____ Date of Birth_____

Patient's First (Given) Name _____ Middle Initial _____

Patient's Gender (assigned at birth) ☐Male ☐Female

Patient's Alternate Name (preferred, maiden, etc.)_____

Patient's Address_____

City _____ State _____ Zip Code_____

Primary Phone Number _____☐Cell _____ ☐Home

Alternate Phone Number _____☐Work_____ ☐Other

Are we able to leave confidential voicemails at this phone number? ☐Yes ☐No

Patient's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Patient's Employment Status: (check one)

☐Full-time ☐Part-time ☐Not Employed ☐Self Employed ☐Retired ☐Military Duty

Patient's Student Status: (check one)

☐Full-time ☐Part -time ☐Not a Student

Is the need for your visit the result of an accident at work or a car accident? ☐Yes ☐No

Insurance Information

Primary Insurance

Insurance Carrier: _____ ID# _____

Group # _____ Effective Date: _____

Are you the subscriber on the policy? ☐Yes ☐No

If no, then who is - ▫ Parent/Legal Guardian: _____ ☐Other

Who will be responsible for the bill after insurance pays? ☐Self ☐Parent/Guardian ☐Other

If not patient, please list name and contact information: _____

Secondary Insurance

Insurance Carrier: _____ ID# _____

Group # _____ Effective Date: _____

Emergency Contact Information

Name (First, MI, Last)

_____

Relationship to patient _____

Date of Birth _____ Phone Number_____ ☐Home ☐Cell

If additional contacts should be on file for this patient's account, please discuss with a support staff member.

Financial Information

For statistical purposes, please share your family's/household's monthly income _____

ADDITIONAL INFORMATION - For statistical and grant writing purposes, please complete the following:
Patient's Race (check **all** that apply) ☐American Indian ☐ Asian ☐ Black ☐ Caucasian/White ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Choose not to answer
Patient's Ethnicity: ☐Hispanic/Latino ☐ Not Hispanic/Latino ☐ Choose not to answer
Does the patient need an interpreter? ☐ Yes - Language? _____ ☐ No
Patient's Language Spoken At Home: ☐ Arabic ☐ ASL ☐ Chinese (Mandarin) ☐ English ☐ Karen ☐ Nuer ☐ Russian ☐ Somali ☐ Spanish ☐ Other _____
Is the patient a migrant farm worker: ☐ Yes ☐ No Is the patient a seasonal farm worker: ☐ Yes ☐ No
Patient's housing status: Are you homeless? ☐ Yes ☐ No If yes, please describe living situation: ☐Homeless shelter ☐Transitional ☐Staying with Friends ☐Street ☐Other
Is the patient a veteran of the United States military? ☐Yes ☐No
Do you currently have any problems with your landlord not making repairs; getting rid of pests; removing mold; or with your utilities? ☐ Yes ☐ No Are you currently experiencing domestic violence, abuse, sexual assault or stalking? ☐ Yes ☐ No Have you recently been denied or lost benefits from the government? ☐ Yes ☐ No Would you like to talk to an attorney for FREE at ODHC? ☐ Yes ☐ No
Patient's country of birth? ☐United States ☐Mexico ☐China ☐Ethiopia ☐Guatemala ☐Honduras ☐Lebanon ☐Russia ☐Somalia ☐South Sudan ☐Vietnam ☐Other _____
Patient's Gender Identity (choose one): ☐Male ☐Female ☐Other ☐Choose not to answer ☐Transgender Male ☐Transgender Female
Sexual Orientation (choose one): ☐Straight (heterosexual) ☐Lesbian or Gay ☐Bisexual ☐Something Else ☐Don't Know ☐Choose not to answer
<u>Preferred Method of Contact</u> ☐Cell ☐Home ☐Work ☐Other ☐Email
Where would you have gone for your healthcare needs if Open Door Health Center did not exist? ☐Would not have been seen ☐Area Medical Clinic or Dental Clinic ☐Emergency Room ☐Urgent Care ☐ Other _____
If the above information is not complete we assume you have chosen not to disclose.

PLACE PATIENT STICKER HERE
Medical Record#
Name:

Consent for Treatment and Authorization to Bill Insurance

Open Door Health Center (ODHC) is dedicated to providing primary care, dental and behavioral health services to Southern Minnesota residents. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. ODHC patients may be referred to providers from other health care specialties outside of ODHC or within the ODHC treatment team/members of the treatment team will share clinical information with each other as is clinically necessary.

Patients shall call 24 hours in advance if the patient cannot keep his/her appointment. Patients may need to reschedule if arrival time is more than 15 minutes after the start of the appointment.

Information about patients will NOT be given to anyone outside ODHC, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission. Patients may consent to the release of his/her information if the patient is age 16 or older for behavioral care and 18 or older for primary or dental care. However, we may release patient's information to others without the patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) There is evidence of child abuse; 5) Patient's clinical records are requested under court order including a subpoena to which the patient does not object promptly; 6) as stated in the HIPAA Notice of Privacy Practices.

There are fees for all services, and the patient should pay on the day the patient is seen. Health insurance policies may cover a portion of the fees and staff will help the patient in making claims. Patient shall tell ODHC staff about changes in financial status including insurance.

The professional staff of ODHC will depend on statements made by the patient, patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at Open Door Health Center may involve the use of lab services provided by Quest. The care team may include a RN Care Coordinator, Behavioral Health Consultant, Community Health Worker, and Insurance Enrollment.

Our health center providers follow best practices when making diagnosis, determine the course of treatment and possible outcomes. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patients accept the risks of medication and other treatment.

I understand, that if I am 16 years of age or older, I may consent for mental health services, substance use disorder screening and treatment, sexually transmitted disease (STD) screening and treatment, and/or pregnancy screening; 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 for 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, treatment and payment for authorized insurance benefits payable to ODHC for any services provided for myself and/or my child as set forth above, including any studies or procedures that ODHC 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.

I have received or was offered and declined a notice of privacy practices.

_____	_____
Patient's or Guardian's Signature	Date
_____	_____
Type or print name	Relationship to patient
_____	_____
Witness	Date

THIS PAGE LEFT BLANK INTENTIONALLY

ELECTRONIC COMMUNICATIONS AUTHORIZATION

Please review and complete the following preferences for electronic communications, so that we may best serve and coordinate your health care needs with the use of the latest technology:

E-Mail Address: _____ @ _____ . _____

☐ YES	Please contact me by e-mail, including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand regular e-mail is insecure in transit over the internet, and so all e-mail communications from the Health Center to me that contain protected health information (PHI) will be encrypted unless I specifically request otherwise.	☐ NO, I do not have e-mail access, or I do not wish to be contacted via e-mail at this time.

Text Message (SMS): (_____) _____- _____

☐ YES	Please contact me by text message (SMS), including but not limited to: appointment reminders, medication refills, care coordination, other Health Center publications, and messaging to support access to my secure patient chart online. I understand the receipt of text messages may incur additional charges from my texting provider, and I am solely responsible for this expense. I understand text messages may be insecure in transit, and so messages from the Health Center to me will not contain protected health information (PHI), unless I specifically request otherwise.	☐ NO, I do not have text (SMS) access, or I do not wish to be contacted via text message at this time.

This authorization is effective as of the date indicated below. I understand I may modify these communication preferences at any time. Please allow 48 business hours for processing.

_____ _____

Patient Name (Print) Signature of Patient, Parent or Guardian

_____ _____

Date Relationship to Patient (if applicable)

OFFICE USE ONLY:

MRN: _____	RCVD: ____ / ____ / ____	☐ ORIGINAL ☐ REVISED	☐ PM UPDATED: _____

THIS PAGE LEFT BLANK INTENTIONALLY

PATIENT HEALTH HISTORY

NAME: _____ **DATE OF BIRTH:**_____

Preferred Name: _____

Date of last medical exam: _____

Medical Provider: _____

Address: _____

Phone: _____

Date of last dental exam: _____

Dentist:_____

Address: _____

Phone: _____

Date of last behavioral health visit: _____

Behavioral Health Provider: _____

Address: _____

Phone: _____

MEDICATIONS (including over-the-counter medications, vitamins, and supplements):

_____ _____ _____

_____ _____ _____

ALLERGIES/Alergias (including medication, food, and environmental):

☐ NO KNOWN ALLERGIES ☐ Aspirin ☐ Barbiturates ☐ Iodine ☐ Latex/rubber
☐ Local Anesthetics ☐ Penicillin ☐ Metals ☐ Sedatives ☐ Sulfa
☐ Other: _____

_____

Do you take, or have ever taken, bisphosphonate drugs (e.g. Fosamax, Aetonel, Boniva)? ☐ YES ☐ NO

Have you ever been **hospitalized**(including for mental health concerns)? ..... . ☐ YES ☐ NO
If yes, what for? _____When?_____

Have you had any **surgeries**? ..... ☐ YES ☐ NO
If yes, what for? _____When?_____

When was your last **colonoscopy**? _____
When was your last **tetanus** shot? _____

~ WOMEN ONLY ~

Are you pregnant or do you think you might be pregnant? ..... ☐ YES ☐ NO
Are you currently breastfeeding? ..... ☐ YES ☐ NO
When was your last Pap smear? _____ Abnormal Pap smears? ☐ YES ☐ NO
When was your last mammogram? _____ Abnormal mammograms? ☐ YES ☐ NO

Reviewed by provider (initials): _____

MEDICAL HISTORY

HEART / BLOODS VESSELS

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Angine (chest pain)
☐	☐	☐	Congenital defect
☐	☐	☐	Endocarditis
☐	☐	☐	Heart attack _____(date)
☐	☐	☐	Heart surgery _____(date)
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Mitral valve prolapse
☐	☐	☐	Murmur
☐	☐	☐	Pacemaker
☐	☐	☐	Bleeding tendency
☐	☐	☐	Blood transfusion
☐	☐	☐	Heart valve replacement _____(date)
☐	☐	☐	Stroke: _____(date)
☐	☐	☐	Other: _____ _____

LUNGS

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Asthma
☐	☐	☐	COPD
☐	☐	☐	Emphysema
☐	☐	☐	Cough with blood
☐	☐	☐	Persistent cough
☐	☐	☐	Shortness of breath
☐	☐	☐	Tuberculosis Was is treated? _____
☐	☐	☐	Other: _____ _____ _____

MOUTH/TEETH

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Bleeding gums
☐	☐	☐	Clenching/grinding
☐	☐	☐	Difficulty chewing
☐	☐	☐	Difficulty swallowing
☐	☐	☐	Jaw pain, clicking, or popping
☐	☐	☐	Difficulty opening mouth
☐	☐	☐	Pain/swelling
☐	☐	☐	Sensitivity
☐	☐	☐	Sores in mouth
☐	☐	☐	Other: _____ _____ _____

STOMACH / INTESTINES

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Crohn's disease
☐	☐	☐	GERD (heartburn/acid reflux)
☐	☐	☐	Hepatitis: A☐ B☐ C☐ Were you treated? _____
☐	☐	☐	Irritable Bowel Syndrome
☐	☐	☐	Jaundice
☐	☐	☐	Stomach ulcers
☐	☐	☐	Ulcerative colitis
☐	☐	☐	Other: _____

ENDOCRINE

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Diabetes: TYPE 1 TYPE 2
☐	☐	☐	Hyperthyroidism (Overactive)
☐	☐	☐	Hypothyroidism (Underactive)
☐	☐	☐	Other: _____ _____ _____

SEXUAL

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	AIDS/HIV
☐	☐	☐	Herpes
☐	☐	☐	HPV
☐	☐	☐	Other: _____ _____ _____

BONES / MUSCLES / JOINTS

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Chronic pain
☐	☐	☐	Joint replacement: which joint/when? _____
☐	☐	☐	Osteoarthritis
☐	☐	☐	Rheumatoid Arthritis
☐	☐	☐	TMJ Disorder
☐	☐	☐	Other:

BRAIN / EMOTIONS / NERVES

Self	Family	N/A	
☐	☐	☐	NONE
☐	☐	☐	Anxiety
☐	☐	☐	Bipolar Disorder
☐	☐	☐	Depression
☐	☐	☐	PTSD
☐	☐	☐	Epilepsy, seizures,
☐	☐	☐	Convulsions
☐	☐	☐	Substance Use Disorder
☐	☐	☐	Autism
☐	☐	☐	Eating Disorder
☐	☐	☐	Schizophrenia
☐	☐	☐	Personality Disorder
☐	☐	☐	ADHD
☐	☐	☐	Learning Disability
☐	☐	☐	Tourett's Syndrome
☐	☐	☐	Other: _____

OTHER

Self	Family	N/A	
☐	☐	☐	Anemia
☐	☐	☐	Glaucoma
☐	☐	☐	Kidney problems
☐	☐	☐	Sinus or nasal problems
☐	☐	☐	Chemotherapy
☐	☐	☐	Radiation
☐	☐	☐	Other Condition(s): _____ _____
☐	☐	☐	Cancer (type): _____ _____
☐	☐	☐	Organ transplant (type): ____ _____

SOCIAL HISTORY

Hazardous material exposure? ☐ NO ☐ YES Specify:_____
Do you use tobacco products? ☐ NO ☐ YES Type: _____ How much/How long? _____
Do you drink caffeinated beverages? ☐ NO ☐ YES Type:_____How much?_____
Do you drink sweetened beverages? ☐ NO ☐ YES Type: _____How much?_____
Are you on any special diet? ☐ NO ☐ YES Type: _____
Do you exercise? ☐ NO ☐ YES What kind/How often? _____

DEVELOPMENTAL HISTORY

Place a check next to any box that is applicable, use the space provided to explain.

☐ Anything unusual about your birth _____
☐ Mother used drugs or alcohol while pregnant with you _____
☐ Experienced medical challenges as an infant or child _____
☐ Experienced significant stressors as a child _____
☐ Experienced any accidents or illnesses that caused injury _____
☐ Happy with the way you were raised _____
☐ Was treated cruelly, neglected, beaten or mistreated as a child _____
☐ Was sexually abused as a child _____
☐ Was in an out of home placement as a child _____
☐ Death by suicide in family? If so, who?_____
Where were you born? _____

FAMILY HISTORY

Are you currently in a committed relationship? ☐YES ☐NO ☐Married
How long have you been together as a couple? _____
Have you previously been (check all that apply) ☐Married ☐Widowed ☐Divorced
Do/Did any of the following apply to your intimate relationship(s)?
☐Sexual Abuse ☐Emotional Abuse ☐Financial Control ☐Verbal Abuse ☐Physical Abuse
☐Chemical Abuse ☐Separation ☐Other Concerns ☐Mental Health Concerns

EDUCATION AND WORK HISTORY

What is the highest level of education you have completed? _____
Did/Do you have any difficulties in school? ☐Learning ☐Relationships (peers/teachers)
☐Behavior ☐Other: _____
Did/Do you receive IEP Services ☐Yes ☐No

Current/Previous Employment:	Time Employed:
_____	_____
_____	_____
_____	_____

TREATMENT HISTORY

Have you ever been in treatment for drugs or alcohol use disorders? ☐Yes ☐No
If yes: Where and When? _____

LEGAL HISTORY

Have you ever been on/in (check all that apply):
☐Probation ☐Jail ☐Prison ☐Parole

RISK ASSESSMENT

Please provide comments on the line

Is there any history of violence in your home?_____☐Yes ☐No
Has CPS ever been involved with your family?_____☐Yes ☐No
Are there any firearms in your home?_____☐Yes ☐No
Do you feel safe in your home?_____☐Yes ☐No
Do you have other safety concerns at this time?_____☐Yes ☐No
Have you ever exchanged sex for food, shelter (or other basic needs) for drugs?_____☐Yes ☐No

CULTURAL/PERSONAL IDENTITY

Religious/Spiritual Affiliation: _____ Practicing? ☐ Yes ☐ No
Socioeconomic Status: ☐ Poor ☐ Working ☐ Middle ☐ Upper Middle/Upper
Additional Cultural Identifiers: _____

SIGNATURE: _____ DATE: _____

CLINIC USE ONLY: **BP/P: _____** **HEIGHT/WEIGHT: _____** **TEMPERATURE: _____**

MRN: _____	RCVD: ____ / ____ / ____	▢ ORIGINAL ▢ REVISED	▢ PM UPDATED:_____