ARE YOU A GOSHEN MEDICAL PATIENT: _____ YES _____ NO

GOSHEN MEDICAL CENTER, INC.

Patient Registration Form Patient Number _____

Name: _____ _____ _____
FIRST MI LAST

Date of Birth: _____/_____/_____ Sex at Birth: ( ) Male ( ) Female
PLEASE CHECK ONE

Social Security Number: _____-_____-_____

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____

Marital Status: _____ Student Status: ( ) Full Time ( ) Part Time
PLEASE CHECK ONE IF APPLICABLE

Ethnicity (CHECK ONE): ( ) Hispanic/Latino ( ) Non-Hispanic/Latino Primary Language: _____

Race (CHECK ONE): ( ) American Indian/Alaska Native ( ) Asian ( ) Black/African American
( ) Native Hawaiian ( ) Pacific Islander ( ) White ( ) More than 1 race

Spouse's Name: _____ Date of Birth: _____/_____/_____

Patient's Employer: _____ Spouse's Employer: _____

Emergency Contact: _____ Telephone: (_____) _____

Responsible Party Information: (Who Pays the Bills?) Guarantor Name: _____

Telephone: (_____) _____ Work Phone: (_____) _____

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Street Address: _____ PO Box: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____-_____-_____ Employer: _____

If Patient is a Minor:

Parent/Legal Guardian of Minor (1)

Name: _____ _____ _____
FIRST MI LAST

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Telephone: (_____) _____ Work Phone: (_____) _____

Please Continue on Next Page

GOSHEN MEDICAL CENTER, INC.

Patient Registration Form (Page 2) Patient Number _____

Parent/Legal Guardian of Minor (2) *[If Applicable]*

Name: _____ _____ _____
FIRST MI LAST

Relationship to Patient: _____ Date of Birth: _____ / _____ / _____

Telephone: (_____) _____ Work Phone: (_____) _____

(***IMPORTANT NOTICE: The Parent/Legal Guardian Information Listed is Not Authorization and/or Designation of a Personal Representative***)

Demographic Characteristics

Characteristics – Special Populations (Data used by Goshen Medical Center due to being a Federally Qualified Health Center which offers the Sliding Fee Discount based on family size and income.)

How long have you lived in the United States? _____ years, _____ months

Are you a US Veteran? ( ) Yes ( ) No

Persons In Household (PLEASE CIRCLE) 1 2 3 4 5 6 7 8 9 10 Other _____

Household Income Range (PLEASE CIRCLE):

<$11,500 *$11,501-15,000* *$15,001-20,000* *$20,001-30,000* *$30,001-40,000*

$40,001-50,000 *$50,001-60,000* *$60,001-70,000* *$70,001-80,000* *$80,001-90,000* *>$90,000*

Within the last 24 months, have you or your parents worked in agriculture either on a farm or at an agricultural based industry? ( ) Yes ( ) No If yes, which applies? (PLEASE SEE BELOW)

( ) Year Round Employment (permanent residence in area)
( ) Migrant (establishes temporary residence in area)
( ) Seasonal (permanent residence in area)

Type of Housing for patient or patient's parent/guardian if a minor (CHECK ONE):

( ) Public Housing ( ) Homeless Shelter ( ) Doubled Up (live with another person or family unit)

( ) Rent or own Home ( ) Street ( ) Transitional (live place to place) ( ) Other _____

Sexual Orientation (CHECK ONE):
( ) Lesbian or Gay
( ) Straight (not Lesbian or Gay)
( ) Bisexual
( ) Something Else
( ) Don't Know
( ) Choose Not to Disclose

Gender Identity (CHECK ONE):
( ) Male
( ) Female
( ) Transgender Male/Female-to-Male
( ) Transgender Female/Male-to-Female
( ) Other
( ) Choose Not to Disclose

Is this visit due to an Accident/Injury: Yes_____ No_____ If yes, Date of Injury: _____ / _____ / _____

I certify that the information given above is true and correct _____
(Patient Signature)

_____
(Parent/Guardian signature if patient a minor)

_____
(Print Name)

_____ / _____ / _____
(Date)

NOTE: Receptionist may request payer source/insurance card or picture identification prior to being seen by provider.

APR2016REV

Patient #:	Patient DOB:

GOSHEN

MEDICAL CENTER, INC.

DESIGNATION OF PERSONAL REPRESENTATIVE

This form must be completed, signed and dated in order to be considered a valid designation.

IMPORTANT NOTICE: ONE COMPLETED FORM IS REQUIRED FOR EACH DESIGNATED PERSONAL REPRESENTATIVE

PATIENT DESIGNATION OF A PERSONAL REPRESENTATIVE

Name of Patient:_____

I hereby designate the person listed below to be my personal representative and request that Goshen Medical Center, Inc. treat the named individual as it would otherwise treat me with regard to my Protected Health Information. I understand that this designation is voluntary. I understand that my disclosure of my protected health information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal confidentiality rules.

PERSONAL REPRESENTATIVE INFORMATION

Name of Personal Representative:_____

Address of Personal Representative:_____

_____

Phone # of Personal Representative:_____

Personal Representatives Relationship to Patient:_____

ACCESS TO PATIENT'S PROTECTED HEALTH INFORMATION

By signing this designation form, I am authorizing my personal representative access to:

_____ All Protected Health Information (e.g. Demographic, medical and billing information)

_____Health Information Only _____ Billing Information Only

_____ Sensitive Health Information (e.g. HIV/AIDS status) _____ Mental Health

_____ **Appointment Information Only**

EXPIRATION AND REVOCATION

_____ This designation will expire on _____

I understand that I may revoke this designation of a personal representative at any time by submitting a written revocation to Goshen Medical Center Inc. Privacy Officer. I understand that I may revoke this designation at any time, except to the extent that action has already been taken to comply with this designation.

Signature of Patient:_____Date:_____

Rosewood Dental Services

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ 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 or 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
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

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. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

GOSHEN MEDICAL CENTER, INC.

Patient Consent for Treatment
And
Consent for and Acknowledgment of Receipt of the Notice of Privacy Practices

Patient Name: _____ Chart: _____

I understand that as part of my health care, Goshen Medical Center, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *Notice of Privacy Practices* prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Goshen Medical Center, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Goshen Medical Center, Inc. has already taken action. I also understand that by refusing to sign this consent or revoking this consent, Goshen Medical Center, Inc. may refuse treatment. Upon refusal to sign this consent, I agree to assume the risk of any injury or damage from the lack of any medical care or treatment arising out of or in connection with Goshen Medical Center's denial to provide any medical care or treatment.

I further understand that Goshen Medical Center, Inc. reserves the right to change their notice and practices in accordance with federal regulations. Should Goshen Medical Center, Inc. change their notice, the revised Notice will be made available.

I understand that as part of Goshen Medical Center's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

☐ I fully understand and accept the terms of this consent.

☐ I fully understand and decline the terms of this consent.

_____ _____

Patient's Signature / Guardian Date

I hereby voluntarily consent to medical and/or dental examinations, treatments and procedures which are deemed necessary in the opinion of my physician, and health care providers, including HIV tests, laboratory tests and x-rays. I understand that my medical information is strictly confidential and is protected by NC General Statute 130A-143 and no guarantees or warrantees have been made to me concerning the results of the examinations, treatments or procedures. My signature acknowledges that I have been given the opportunity to ask questions about this consent form.

_____ _____

Patient's Signature / Guardian Date

The Federally Supported Health Centers Assistance Acts (FSHCAA) of 1992 (Pub. L. 102-501) and 1995 (Pub. L. 104-73) extend Federal Tort Claims Act (FTCA) protections under 28 U.S.C. 1346(b), 2401(b), and 2679-81 to eligible health centers funded under the Health Center Program, section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended. Goshen Medical Center, Inc. is protected under this legislation.

GOSHEN MEDICAL CENTER, INC.

Rosewood Dental Services
104C Adair Drive
Goldsboro, NC 27530
919-648-4437

Effective November 7, 2017

Any dental patient who misses three or more appointments at ANY of our offices will no longer be allowed to schedule appointments in advance.

We will still be willing to see patients in this situation, however it will then become the patient's responsibility to call when they know they can come, to see if we can accommodate them into our schedule within the next day or two. Every effort will be made to see a patient in this situation, but if the patient is not willing to do this, it will then be necessary for them to find another office.

We consider a missed appointment as any appointment a patient fails to show up for, or calls and cancels without giving our office enough time to fill the patient's appointment slot. Therefore, if it becomes necessary to cancel an appointment, please call our office as soon as possible. We recommend at least two days in advance.

Any patient who arrives later than their appointment time may be considered to have failed their appointment.

We always try to call and remind patients of their appointments as a courtesy, but this is not guaranteed. Once a patient makes an appointment with our office, IT IS THE PATIENT'S RESPONSIBILITY TO REMEMBER IT.

We will not make exceptions to this policy.

Signature of patient or guardian _____ Date _____

MR#_____

"Self-Declaration"

Sliding Fee Discount Program

We appreciate the opportunity to provide you with health services. All patient records are strictly confidential and cannot be released without your permission. Services rendered are expected to be paid on the date of service. The Sliding Fee Discount Program is based on total household size and income. In order to qualify, you must provide one of the following sources of information:

- Copy of most recent paycheck or paycheck stubs.
- Letter on agency letterhead verifying financial status, i.e., Social Security, Housing Authority
- Temporary Assistance for Needy Families documentation.
- Alimony and/or Child Support amount reported on sliding fee document.
- Dated letter from employer stating amount of gross payment (does not need to be notarized)
- Copy of Federal tax return or W-2's.
- Student Grant Information/SARs (Student Aid Reports) (self-declare on sliding fee
- If self-employed, tax forms from most current year (W-2's or 1099)
- Dated letter from head of household/family where patient resides stating financial responsibility.

Self-Declaration of required information:

This document is only used during your initial visit under the Sliding Fee Discount Program

My current total household income is $_____

Total number of household members that you are financially responsible for_____

Name	DOB	Relationship

I have read the above information and understand the qualifications and documentation necessary to apply for the Sliding Fee Discount Program.

I further understand to bring income verification, if possible, upon the next visit, or within 6 months of the initial visit of the sliding fee calendar year. If I do not provide the necessary information, I will be required to pay 100% of charges for services received at Goshen Medical Center.

Patient Signature: _____Date_____

Staff Signature: _____Date_____

MR #_____

SLIDING FEE DISCOUNT PROGRAM ELIGIBILITY FORM

Name	Guarantor Relationship	Date of Birth	Income (Gross)	Frequency (Weekly, Bi-Weekly, Hourly, Monthly or Yearly)	Date all Documentation Received	Document Received
	Self					

Household/Family is all persons physically residing in the same home who are the legal responsibility of the guarantor	**Income**	**Household**

Documentation must be provided by the patent or guarantor to determine eligibility for Sliding Fee Scale

1. I understand that the information I provide on this form is subject to verification by Goshen Medical Center.
2. I understand and agree to adhere to all terms and conditions of the Sliding Fee Discount Program.
3. I do herby attest that this information is true, accurate, and complete to the best of my knowledge and that I understand that any falsification, omission, or concealment of material fact may subject me to disqualification from the Sliding Scale Discount Program.
4. I understand that it is my responsibly to notify Goshen Medical Center of any changes in income or insurance.

ACCEPTABLE INCOME DOCUMENTATION

PAYCHECK STUBS
1099'S
W2 OR TAX FORMS
COMPANY LETTER STATING ANNUAL EARNINGS (LETTER MUST CONTAIN A CONTACT PERSON AND PHONE NUMBER)
OFFICIAL LETTERS/DOCUMENTS FROM SOCIAL SECURITY, COURTS, CHILD SUPPORTS ESC, ETC...
VERIFICATION OF INCOME FORM COMPLETED AND SIGNED BY THE EMPLOYER

☐ I do not wish to enroll myself in the Sliding Fee Program currently.

PATIENT/GUARDIAN SIGNATURE _____ PRINTED NAME _____ DATE _____

GOSHEN STAFF SIGNATURE _____ PRINTED NAME _____ DATE _____

GOSHEN STAFF SIGNATURE _____ PRINTED NAME _____ DATE _____