KONZA PRAIRIE Community Health Center

Patient Update Form - Medical/Dental

Konza Prairie Community Health Center (KPCHC)
Any space left blank will be considered "Refuses to answer."

PATIENT DEMOGRAPHIC INFORMATION

First Name (Legal):	M.I.	Last Name (Legal):	Preferred Name:
Date of Birth:	Phone #:	Previous Name(s):	Social Security #:

Marital Status:
☐ Married ☐ Divorced
☐ Partner ☐ Legally Separated
☐ Single ☐ Widow(er)

Patient Pronouns:
☐ She/Her
☐ He/Him
☐ They/Them

Mailing Address (# of an apartment if applicable):

PO Box:	City:	State:	Zip code:

Appointment Reminders and Promotions: ☐ Text ☐ Email: _____
(Please see Communication Preferences on Page 2)

Konza Prairie Community Health Center is a Federally Qualified Health Center (FQHC). We receive federal funding and grants. As part of this funding, we are required to collect income data on all patients at least once a year. This information is used to set up programs to meet our patient's needs. Patients must be re-certified on or before their sliding fee anniversary date to receive a discount for services.

INSURANCE INFORMATION

Primary Health Insurance		Primary Dental Insurance	
Company Name	Group Number	Company Name	Group Number
ID Number	DOB:	ID Number	DOB:
Policyholder:	SSN:	Policyholder:	SSN:

EMERGENCY CONTACT INFORMATION

Name:	Phone Number:
Relationship:	☐ Grant access to: Release of PHI (Access to all medical, billing, and scheduling information)
Name:	Phone Number:
Relationship:	☐ Grant access to: Release of PHI (Access to all medical, billing, and scheduling information)

Race:
☐ Asian ☐ Other Asian
☐ Native Hawaiian ☐ Filipino
☐ Other/Pacific Islander ☐ Samoan
☐ Black/African American ☐ Chinese
☐ American Indian/Alaska Native ☐ Guamanian or Chamorro
☐ White ☐ More than one Race
☐ Other:

Sexual Preference:
☐ Lesbian or Gay
☐ Heterosexual
☐ Bisexual
☐ I Do Not Know
☐ Do Not Disclose

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male (F to M)
☐ Transgender Female (M to F)
☐ Other:
☐ Do Not Disclose

Are you a registered voter?
☐ No ☐ Yes

Would you like more information on voting?
☐ No ☐ Yes

Main Language:
☐ English
☐ Spanish
☐ Other:

Ethnic Group:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Are you a refugee? ☐ No ☐ Yes
Are you a migrant (Has temporary home)? ☐ No ☐ Yes
Are you a seasonal worker (Doesn't establish a temporary home)? ☐ No ☐ Yes
Are you Homeless? ☐ No ☐ Yes

Do you need an interpreter? ☐ No ☐ Yes

Do you have an Advance Directive for healthcare, Living Will or a Do Not Resuscitate order?

☐ No ☐ Yes If not, are you interested in more information? ☐ No ☐ Yes

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Name:	DOB:

CONSENT FOR TREATMENT

Initials

I request consent for professional health care from KPCHC providing medical, dental, and/or behavioral health services (or to my minor child) including Family Planning, Early Detection Works, and other sponsored services. All services are voluntary, prohibit coercion, and require no prerequisites. I understand that I may choose to stop services when you decide. If the patient is a minor or incapacitated adult, I authorize that I am the parent, legal guardian, or designated personal representative of the named patient. I have the legal authority to consent to KPCHC providers and staff consent for medical, dental, behavioral health treatment deemed necessary for the patient. No court orders prohibit me from signing this consent. I will have to present the proper legal documentation to KPCHC if staff requests. **I understand that if there are other adults who bring the child to appointments, I will have to fill out the Consent for Children/Minors form at the top of page 6.**

ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Initials

KPCHC participates in electronic Health Information Technology (HIT). This technology allows a provider or a health plan to make a single request through a Health Information Organization (HIO), to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIO's are required to use appropriate safeguards to prevent unauthorized uses and disclosures. You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you choose this option, you do not have to do anything. Second, you may restrict access to all your information through an HIO (except by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. You cannot restrict access to certain information only; your choice is to permit or restrict access to all your information. If you have questions regarding HIT or HIO's, please visit http://www.KanHIT.org.

APPOINTMENT POLICY

Initials

Patients are expected to attend all KPCHC appointments. New patients must arrive twenty (20) minutes prior to their appointment to fill out necessary documents. Established patients or same-day visits must arrive fifteen (15) minutes prior to their appointment.

Arriving more than ten (10) minutes after your appointment will result in rescheduling your appointment.

If the patient is unable to attend their appointment, they must notify KPCHC 24 hours before their appointment to cancel or reschedule. Failure to cancel, notify, or attend your appointment will result in a No Call/No Show. If a patient No Call/No Shows (3) three appointments in 12 consecutive months, they may be discharged from care and will be notified by certified mail.

If there is a barrier preventing you from attending to your appointments, please inform the staff.

PAYMENT AGREEMENT

Initials

I agree that I will quickly and in full, pay for any patient responsibility for services received at KPCHC. If I am insured, it is my responsibility to check with my insurance company to see what services are covered.

At KPCHC, we want to work with you to meet your healthcare needs at affordable costs. Please call the billing department to arrange a payment plan for any balances due. KPCHC accepts payments in the office, by phone or mail.

I understand that if I do not make a payment or a payment plan on any amounts due from the date of the first statement, KPCHC may send my account to a third-party collection agency. Refusal to pay your bill, with KPCHC or the third-party collection agency, could result in being discharged as a patient from KPCHC.

COMMUNICATION PREFERENCES

KPCHC is committed to protecting your information. KPCHC will send you important information about your healthcare using the methods you prefer. Please check the box next to the forms of communication you authorize KPCHC to use with you.

- ☐ Email (NECESSARY - to sign up for the Patient Portal, use Telemedicine, receive appointment reminders and important health updates).
- ☐ Text Message (NECESSARY - to check-in for visits on your phone and receive mobile appointment reminders).
- ☐ Patient Portal (NECESSARY - to communicate securely and electronically with your care team-**MUST AUTHORIZE EMAIL**).

KPCHC will never share your information with any outside organization. You may opt out of receiving electronic communication at any time by contacting KPCHC Front Desk. The Patient Portal is a secure method, but text, email, and voicemail may be considered unsecure.

I acknowledge that I have read, understand, and fully accept all the terms of the guide and policies above.

Signature of Patient or Legal Guardian	Date

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PATIENT HEALTH QUESTIONNAIRE

Have you seen any providers outside of KPCHC in the past 2 yrs? (ie. PCP OB/GYN, GI, etc.) ☐ No ☐ Yes

Name of Doctor/Clinic	Type of Doctor/Clinic

CURRENT MEDICATION LIST (PRESCRIBED & OVER THE COUNTER)

Name	Dosage	Frequency	Reason

Please list below any current allergies to medicine, food, latex, vaccines, contrast dye, etc?

Name	Reaction

Gynecological History

Are you currently pregnant? ☐ No ☐ Yes	If yes, are you breastfeeding or pumping?	
Age at onset of menses:	Number of Pregnancies:	
Date of last menstrual cycle:	Living Children:	Miscarriages:
Have you had any menstrual issues (please explain):		
Have you had any post-menopausal bleeding?		

Have you had any of the following screenings? Please indicate month/year

Colon Screenings:	Flu Shot:	Blood Sugar/A1c Test:
☐ FIT	Pap Smear/Pelvic Exam:	Diabetic Eye Exam:
☐ Cologuard	COVID Vaccine & Type:	STD/STI/HIV Screening:
☐ Colonoscopy	PSA:	Mammography:

Habits

Do you drink alcohol? If so, how often? ☐ No ☐ Yes
Do you use tobacco, smokeless tobacco, or vaping products? If so, what kind and frequency? ☐ No ☐ Yes
Do you use any recreational drugs? If so, what kind and frequency? ☐ No ☐ Yes
Have you had any exposure to toxic chemicals? If so, what chemical(s)? ☐ No ☐ Yes

Administrative Use Only Below

Scanned to Chart Documents	**☐ No ☐ Yes ☐ Not Applicable**	**Staff Initials:**
Tobacco Education Intervention Given	**☐ No ☐ Yes ☐ Not Applicable**	**Staff Initials:**
PHQ-9 Needed (All Patients Annually)	**☐ Yes**	**Staff Initials:**