



PATIENT REGISTRATION FORM

Section I					Demographic Information		
Legal First Name	MI	Last	Preferred Name	- - - Social Security #			
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Birth Sex	<input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (FtoM) <input type="checkbox"/> Male <input type="checkbox"/> Neither Exclusively Male or Female <input type="checkbox"/> Gender Identity (18+)	<input type="checkbox"/> Decline <input type="checkbox"/> Other <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Other <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Decline <input type="checkbox"/> Sexual Orientation (18+)	<input type="checkbox"/> Other <input type="checkbox"/> Transgender Female (MtoF)	____/____/____ DOB			
Marital Status		Race					
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown		<input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other Race:Specify _____					
Ethnicity		Primary Language Spoken		Employment Status			
<input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Non-Latino/Hispanic <input type="checkbox"/> Not Reported		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other:Specify _____		<input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			
Veteran		Seasonal or Migrant Worker		Current Living Arrangement			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Seasonal <input type="checkbox"/> Migrant <input type="checkbox"/> No		<input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Doubled Up <input type="checkbox"/> Transitional <input type="checkbox"/> Street <input type="checkbox"/> Other			
Mailing Address					Zip Code		
Email Address				Home Phone		Work Phone	
()				<input type="checkbox"/> Home <input type="checkbox"/> Mobile		<input type="checkbox"/> Voice <input type="checkbox"/> E-Mail <input type="checkbox"/> Text <input type="checkbox"/> No Contact	
Mobile Phone				Preferred Phone #		Preferred Appt. Reminder Method	
<input type="checkbox"/> SCMC Employee <input type="checkbox"/> Internet <input type="checkbox"/> Outside Provider <input type="checkbox"/> Other: _____				<input type="checkbox"/> Friend <input type="checkbox"/> Walk In		PCP (If Not SCMC)	
Referral Source					PCP (If Not SCMC)		

Section II					Guarantor (Financial Responsible Individual)		
<input type="checkbox"/> PATIENT IS GUARANTOR (No need to complete remainder of)					<input type="checkbox"/> Person <input type="checkbox"/> Company		
Patient's Relation to Guarantor					Guarantor's Social Security Number		
<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Employee <input type="checkbox"/> Special Dependent <input type="checkbox"/> Grandchild <input type="checkbox"/> Other <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Niece/Nephew							
Guarantor's Legal First Name			Middle		Last		
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Birth Sex			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Unknown <input type="checkbox"/> Marital Status		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Sign Language <input type="checkbox"/> Other:Specify _____ <input type="checkbox"/> Primary Language Spoken		
Address			Zip Code		DOB		
____/____/____ DOB							
Address				Zip Code		DOB	
() Address				() Zip Code		() DOB	
Email Address				Home Phone		Work Phone	
() Email Address				() Home Phone		() Work Phone	

Insurance Information

PRIMARY INSURANCE				SECONDARY INSURANCE			
Type:		<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None		Type:		<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> None	
Plan Name:				Plan Name:			
Subscriber's Name				Subscriber's Name			
Subscriber's Address				Subscriber's Address			
Subscriber Zip Code		Subscriber Date of Birth		Subscriber Zip Code		Subscriber Date of Birth	
Subscriber's SSN		<input type="checkbox"/> Male <input type="checkbox"/> Female Subscriber's Gender		Subscriber's SSN		<input type="checkbox"/> Male <input type="checkbox"/> Female Subscriber's Gender	
Group Number				Group Number			
Policy Number		Copay		Policy Number		Copay	
Subscriber's Relation to Patient				Subscriber's Relation to Patient			

PHARMACY INFORMATION			
PRIMARY PHARMACY		SECONDARY PHARMACY	
Pharmacy Name		Pharmacy Name	
Pharmacy City	Pharmacy State	Pharmacy City	Pharmacy State

Do you have any problems with: Vision Hearing Reading Speaking

IN CASE OF EMERGENCY		
Name of Contact	Relationship to Patient	() Phone Number

I, _____, give my permission to release any health information to the following:

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

Patient/Guardian Signature	Date
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Consent for Treatment/Services

I hereby apply for care under this program based on the information give and permit the personnel of South Central Medical Center to verify any of the information I have furnished.

Initials

I understand that demographic (age, sex, rage, income, etc.) information about me and/or my family and information about the number of services that I/we receive may be used without my name or other information that would individually identify me. This information will assist South Central Medical Center in its efforts to obtain services that will help me or my family.

Initials

I hereby authorize the staff and personnel of South Central Medical Center to perform such diagnosis procedures and other medical procedures as they may deem necessary or advisable from time to time.

Initials

I hereby authorize South Central Medical Center to release any appropriate medical information to any hospital to which I/my family may need to be admitted and/or as allowed under the SCMC Notices of Privacy Practices

Initials

I further understand that if I have failed to give correct and complete information regarding the questions I have been asked, I/my family as listed is subject to 100% payment billing and subsequently standard collection procedures for any delinquent accounts regardless of payment

Initials

I understand that I am responsible for the payment for all services received at South Central Medical Center that are not paid for by any other source.

Initials

Patient/Guardian Signature	Date

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal health information in compliance with the law. SCMC's Notice of Privacy Practices states:

1. our obligation under the law with respect to your personal health information.
2. how we may use and disclose the health information we keep about you.
3. your rights relating to your personal health information.
4. our rights to change our Notice of Privacy Practices.
5. how to file a complaint if you believe your privacy rights have been violated.
6. the conditions that apply to uses and disclosures not described in this notice.
7. the person to contact for further information regarding our privacy practices.

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.

I, _____, hereby acknowledge that I have been offered/received a copy of the Notice of Privacy Practices.

Patient/Guardian Signature	Date

Medical Home Agreement with South Central Medical Center

This Medical Home Agreement is an AGREEMENT between YOU and YOUR Community Health Center PROVIDER, to focus on meeting ALL of your healthcare NEEDS.

The principles of the Medical Home with South Central Medical Center are as follows:

Personal Physician/Provider- each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician/Provider Directed Medical Practice- the personal physician leads a team of individuals at the practice level who collectively take a responsibility for the ongoing care of patients.

Whole Person Orientation- the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventative services; and end of life care.

Quality and safety- are the hallmarks of care at South Central Medical Center

Enhanced access to care- South Central Medical and Resource Center is available through systems such as open scheduling and expanded hours to provide you with the best care.

As a SCMC patient, there are rules you must follow. It is your responsibility to SCMRC to:

Be aware of SCMRC's office hours so you know when you can be seen.

Monday through Thursday: 8 am to 5 p.m.

Friday: 7 am to 8:45 am (walk in, no appointment necessary) 9 am to 1 pm regular appointment scheduling

Call for an appointment as early as possible and keep the appointments you make.

You may have to wait up to two (2) weeks to be seen for checkups and shots.

Even if you have an appointment, you may have to wait past that time to see your provider, you should ask to reschedule if you cannot wait.

If you cannot keep your appointments, you must call the provider at least 24 hours in advance to cancel or reschedule your appointment. SCMRC reserves the right to dismiss you as a patient if you continually miss your appointments.

You must reschedule your appointment for another time if you will be more than 15 minutes late for any scheduled appointments, even if you call in advance to say you will be late

When you call SCMC you should always:

Tell the staff why you need an appointment. Please inform the staff if this is an acute situation that needs to be addressed within 24 hours

Have your medical insurance information available, if applicable.

Call SCMRC if your problem gets worse before your scheduled visit. Ask to speak to our triage nurse and tell them your symptoms, they can recommend if you need to be seen sooner than your scheduled appointment.

During your SCMC visit you should always:

Give the staff information they need to help you. This includes telling them about all of your symptoms.

Tell the staff and providers ALL of your medical history.

Inform SCMC of ALL prescription drugs, over the counter medications and herbal supplements you are using.

Inform SCMC of any other health care appointments you have so they can follow up with those providers.

Follow the treatment plans and guidelines that your provider gives you. SCMC providers practice evidence based care which includes the patient's participating in their healthcare options, treatments and referrals. All patients are asked to participate in the coordination of self care management goals and participate in health education activities as recommended by their provider.

After Hours Coverage:

SCMRC has an after hour's nurse line available for all patients anytime our office is not available by calling (405) 756-1414 to reach the after hours service. The nurses will provide you advice on how to handle your medical situation if SCMC is not available and will contact your physician if they feel necessary to have you receive specific instructions from your provider.

If you think you are having a true *medical* emergency, go to the nearest emergency room or call 911

As a patient of SCMC you should expect the providers and staff to treat you professionally and respectfully. It is also expected that you and your family members treat the providers and staff respectfully and refrain from using rude, offensive, or threatening behavior. You may call Dana Ramming, Chief Executive Officer, at 405-756-1414 to report any complaints or concerns regarding providers and staff.

I select:

- Dr. Don K. Ferguson
- Lindsey Conner APRN
- Novyce "Ginger" Ferguson, APRN-CNP
- Jana Bolling APRN (School Site)
- Charles "Blaise" Jones, PA-C

as my personal provider at SCMC. I understand this provider will be my primary contact for my medical care at SCMC, however I understand that in an acute situation I could be scheduled to see any available member of the medical team to ensure that all of my needs are met. I understand that SCMC strives to schedule every patient with their personal clinician but due to vacations, seasonal events and/or unforeseen events, you may have to be seen by another providers at SCMC.

South Central Medical and Resource Center is committed to providing the highest quality of care to all of our patients. In order to provide you with the highest quality of care it is important that we are informed of any other health care providers who provide you care. Please complete the following form as completely as you can:

Provider Name	Phone Number	Specialty
Provider Name	Phone Number	Specialty
Provider Name	Phone Number	Specialty
Provider Name	Phone Number	Specialty
Provider Name	Phone Number	Specialty
Provider Name	Phone Number	Specialty

Patient's Printed Name

Patient/Guardian Signature

Date

