PATIENT REGISTRATION

Patient Information:

Date: _____

Name: _____
(First) *(Middle)* *(Last)*

Address: _____

Social Security Number: _____ Home phone: (____)_____

Date of Birth: _____ Marital Status: _____ Sex: _____

Race: (please circle one) American Indian, Asian, Black, White, Native Hawaiian, Other Pacific Islander

Ethnicity: (please circle one) Hispanic or Latino, Not Hispanic or Latino

Are you a veteran? _____Yes _____No. Are you homeless? _____Yes _____No

Insurance: _____Yes _____No. If you do not have insurance, would you like to get information about our reduced fee program? _____Yes _____No

Emergency Contact Person:

_____
(Name) *(Relationship to patient)*

_____ *(Address)*
(Phone)

Person Responsible for Payment:

(Complete only if patient is less than 18 years old)

Name: _____ Relationship to patient: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

Keystone Health
PATIENT'S AGREEMENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
(first) (middle) (last)

Please list individuals with whom we may share your medical/dental and/or billing information. This means we can verbally share medical or financial information as well as provide printed copies of items contained in your medical/dental record or billing statements. Any individual listed may also pick up information for you at the office, such as approved prescriptions, lab or test slips, work or school notes, etc. The patient or official designee must initiate and sign a release of information form if a complete copy of the medical/dental record is requested. It is your responsibility to notify Keystone of any changes. This agreement information remains valid until revoked in writing.

Keystone Health utilizes an Electronic Health Record; all Keystone medical sites share one record. Any person you authorize will have access to your information at any Keystone site.

There are specific visits that will require the patient or authorized person/official designee to sign a release. The visits could include behavioral health, HIV and confidential women's visits.

If the patient is under age 18, the parent and/or guardian should be listed below.
Financial/Medical/Dental Information

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health care.

Cell phone:_____ (You will receive a text message)

E-mail:_____ (You will receive an email)

By signing, I give my permission to Keystone Health to share my Protected Health Information, as permitted by law or regulation; to the individuals listed and that I received a copy of Keystone Health Center's Financial Agreement and Notice of Privacy Practices.

Print Name _____ Relationship _____

Signature _____ Date _____

_____
Staff Initials

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PARENTAL/GUARDIAN CONSENT FOR TREATMENT AND PROCEDURES
Keystone Health

Child Name _____ DOB _____

COMPLETE ONE:

Parent:

I, _____ am the parent of the child listed above and there are no court orders in effect that would restrict me from providing consent for treatment and procedures. I give the person(s) listed below the power to consent to necessary medical/dental treatment and procedures and/or behavioral health services for the child listed above.

Legal Guardian/Custodian

I, _____ am the legal guardian or legal custodian of the child listed above, pursuant to court order (copy attached, if available), and there are no court orders in effect that would restrict me from providing consent for treatment and procedures. I give the person(s) listed below the power to consent to necessary medical/dental treatment and procedures and/or behavioral health services for the child listed above.

Person(s) permitted to bring child for appointments and consent for medical/dental and behavioral health services and procedures:

Print first and last name:	Relationship:
_____	Mother
_____	Father
_____	_____
_____	_____
_____	_____

The person(s) named above may consent to the child's (**cross out any that do not apply**): medical, dental, surgical, developmental, and/or behavioral health services or treatment and procedures.

Medical/Dental/Behavioral Health information may be provided to above person(s) as it relates to the appointment in which they are involved.

I am giving the power to consent freely and knowingly in order to provide for the child and not as a result of pressure, threats or payments by any person or agency. This consent is to remain in effect until it is revoked in writing.

My signature represents my agreement with the above.

Date: _____

_____ _____

Printed Name of Parent or Guardian/Custodian Signature of Parent or Guardian/Custodian

For Verbal Consent, two (2) staff must witness/attest:

_____ _____

Signature of witness No.1 Signature of witness No. 2

Keystone Audiology and Speech Speech/Language History Form--Child

Child's Name: _____Birthdate:_____Date Completed:_____
Mother: (Dr/Mrs/Miss/Ms)_____ Father: (Dr/Mr)_____
Sibling names and ages: _____
_____
Referring Provider:_____
Current Medical Conditions: _____
_____
Current Medications: _____
_____
Hospitalizations & Surgeries: _____
_____
Allergies: _____
Family History: Is there family history of:
Speech/Language Difficulties Yes/No Hearing Impairment/Deafness Yes/No
Learning Difficulties Yes/No Developmental Difficulties Yes/No
If yes to any of the above, please describe: _____
_____
Developmental History:
Was there anything unusual about the pregnancy or birth? Yes/No
If yes, please explain: _____
_____
Please provide the age your child reached the following milestones:
____Sat alone ____Crawled ____Walked ____Completed toilet training
____Babbled ____Said first word(s) ____Combined 2 words ____Spoke in short sentences
Does your child receive any other therapy through another provider? (Ex: school, Intermediate unit)
____ST ____OT ____PT ____Behavioral ____Vision
Please explain: _____
_____
Speech and Language Development:
How does your child prefer to communicate (please check)?
____gestures ____words ____phrases ____sentences ____sign language ____communication device
Was your child's speech/language development progressing normally then stop or regress? Yes/No
Is your child's speech difficult to understand? Yes/No
What speech sounds does s/he have difficulty pronouncing? _____
_____
Your child's voice is: ____normal ____hoarse ____too high ____too low ____too loud ____too soft
Does your child stutter? Yes/No Does your child echo words/phrases? Yes/No
Does your child: Identify objects? Yes/No Understand actions (verbs)? Yes/No
Ask questions? Yes/No Understand what you are saying? Yes/No
Follow directions? Yes/No Respond correctly to yes/no questions? Yes/No
Respond correctly to "Wh" (who, what, where, etc.) questions? Yes/No
Has your child ever receive a speech/language evaluation? Yes/No Date_____Where?_____
Has your child received speech/language therapy previously? Yes/No When?_____How long?_____
Please describe your current concerns about your child's speech/language:_____
_____
_____

Is your child aware of/frustrated by any speech/language difficulties? Yes/No Describe_____

_____

What do you see as your child's most difficult problem at home?_____

_____

Oral Motor and Feeding History:

Does your child have cleft lip or palate? Yes/No

Has your child had feeding/eating difficulties (biting, choking, swallowing, chewing)? Yes/No

If yes, please explain:_____

_____

Does your child put toys in mouth? Yes/No Drool? Yes/No Feed self with utensils? Yes/No

Does your child have food allergies? Yes/No

If yes, please explain:_____

_____

Does your child have strong food preferences/aversions? Yes/No

If yes, please explain:_____

_____

Does your child brush his/her teeth and/or allow brushing? Yes/No

If no, please explain:_____

_____

Behavioral Characteristics: Please check the ones below which describe your child:

___cooperative	___separation difficulties	___willing to try new activities
___attentive	___restless/overactive	___plays alone for reasonable length of time
___stubborn	___destructive/aggressive	___easily frustrated/impulsive
___poor eye contact	___inappropriate behavior	___easily distracted/short attention span
___withdrawn	___self-abusive behavior	___repetitive actions (spinning, jumping, etc.)

Favorite Activities:

Please list your child's favorite activities, hobbies, toys, games, etc._____

_____

School History:

Name of school:_____Grade:_____

What are your child's strengths and/or best subjects?_____

_____

Is your child having difficulty with particular subjects? Yes/No If yes, which?_____

_____

Is your child receiving help at school or home (support services, tutoring, etc.)? Yes/No

If yes, please explain:_____

_____

What do you see as your child's most difficult problem at school? _____

_____

Other:

Date of last hearing screening/test:_____ Results:_____

Date of last vision screening/test:_____ Results:_____

Is there any other information you feel the speech therapist should know about your child (serious medical condition, custody arrangements, fears, etc.)? _____

_____

_____

_____

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:
□ White/Caucasian □ Black/African American □ Asian □ American Indian
□ Native Hawaiian □ Other Pacific Islander □ Multi-racial

Ethnicity- relates to nationality and culture:
□ Latino/Hispanic □ Non Latino

Do you live in public housing:
□ Yes □ No

Family Size	Annual Family Income			
1	☐ $15,075 and below	☐ $18,090 and below	☐ $21,105 and below	☐ $24,120 and above
2	☐ $20,300 and below	☐ $24,360 and below	☐ $28,420 and below	☐ $32,480 and above
3	☐ $25,525 and below	☐ $30,630 and below	☐ $35,735 and below	☐ $40,840 and above
4	☐ $30,750 and below	☐ $36,900 and below	☐ $43,050 and below	☐ $49,200 and above
5	☐ $35,975 and below	☐ $43,170 and below	☐ $50,365 and below	☐ $57,560 and above
6	☐ $41,200 and below	☐ $49,440 and below	☐ $57,680 and below	☐ $65,920 and above
7	☐ $46,425 and below	☐ $55,710 and below	☐ $64,995 and below	☐ $74,280 and above
8	☐ $51,650 and below	☐ $61,980 and below	☐ $72,310 and below	☐ $82,640 and above
9	☐ $56,875 and below	☐ $68,250 and below	☐ $79,625 and below	☐ $91,000 and above
10	☐ $62,100 and below	☐ $74,520 and below	☐ $86,940 and below	☐ $99,360 and above

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