OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

PATIENT INFORMATION

DATE: _____

_____ ____/____/____ M_| F_ _____-_____-_____
FIRST NAME MIDDLE INITIAL LAST NAME DATE OF BIRTH SEX SOCIAL SECURITY #

___(_____)_____ ___(_____)_____ ___(_____)_____
CELL NUMBER HOME NUMBER WORK NUMBER

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

_____ _____ _____
EMAIL ADDRESS PREFERRED NAME (If different from above) TYPE (birth, maiden, alias, preferred)

PROVIDER SEEN MOST OFTEN: _____

PREFERRED APPOINTMENT REMINDER METHOD: (circle one) NO REMINDER PHONE CALL TEXT MESSAGE

EMPLOYER:

_____ (_____)_____ _____
EMPLOYER PHONE NUMBER OCCUPATION

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

I ALLOW THE FOLLOWING DISCLOSURE OF HEALTHCARE INFORMATION TO THE FOLLOWING CONTACTS. THIS AUTHORIZES STAFF TO SPEAK TO THE LISTED CONTACTS FOR ALL APPOINTMENTS, CLINICAL INFORMATION AND FINANCIAL INFORMATION.

CONTACTS:

PRIMARY CONTACT RELATIONSHIP: _____ (_____)_____ (_____)_____
PHONE NUMBER TYPE (CELL / HOME)

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SECONDARY CONTACT RELATIONSHIP: _____ (_____)_____ (_____)_____
PHONE NUMBER TYPE (CELL / HOME)

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

GUARANTOR (Responsible party for payment). Complete only if the responsible party is NOT the patient. ___/___/___ _____-_____-_____
DATE OF BIRTH SOCIAL SECURITY #

_____ _____ _____ _____ _____ _____
FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SIGNATURE _____ _____ _____
PATIENT'S SIGNATURE / LEGAL GUARDIAN DATE TIME

_____ _____ _____
WITNESS DATE TIME

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HOUSEHOLD INCOME SURVEY - MONTHLY

2025

Date: _____ **Name:** _____ **DOB:**_____

THIS IS ONLY A SURVEY. This information is only used to gain insight into the needs of our patients. Please circle the family size and monthly income that best represents your household.

Family Size	Level 1	Level 2	Level 3	Level 4
1	0	1,305	1,957	Over
	1,304	1,956	2,608	2,608
2	0	1,764	2,645	Over
	1,763	2,644	3,525	3,525
3	0	2,222	3,332	Over
	2,221	3,331	4,442	4,442
4	0	2,680	4,020	Over
	2,679	4,019	5,358	5,358
5	0	3,139	4,707	Over
	3,138	4,706	6,275	6,275
6	0	3,597	5,395	Over
	3,596	5,394	7,192	7,192
7	0	4,055	6,082	Over
	4,054	6,081	8,108	8,108
8	0	4,514	6,770	Over
	4,513	6,769	9,025	9,025
9	0	4,972	7,457	Over
	4,971	7,456	9,942	9,942
10	0	5,430	8,145	Over
	5,429	8,144	10,858	10,858
11	0	5,889	8,832	Over
	5,888	8,831	11,775	11,775
12	0	6,347	9,520	Over
	6,346	9,519	12,692	12,692
13	0	6,805	10,207	Over
	6,804	10,206	13,608	13,608
14	0	7,264	10,895	Over
	7,263	10,894	14,525	14,525
15	0	7,722	11,582	Over
	7,721	11,581	15,442	15,442

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CHILD HEALTH HISTORY

CHILD HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of birth: _____

Has the child ever had any of the following conditions?

____	ADD/ADHD	____	Chronic Ear Infections	____	Inguinal Hernia
____	Anemia	____	Congenital Heart	____	Liver Disease
____	Asthma	____	Congenital Anomaly	____	Migraine Headaches
____	Atopic Dermatitis	____	Diabetes	____	Mononucleosis
____	Behavior Problems	____	Down Syndrome	____	Obesity
____	Blood Disorders	____	Ear Tubes	____	Pneumonia
____	Blood Transfusion	____	Epilepsy	____	Premature Birth
____	Bronchiolitis	____	Gastroesophageal Reflux	____	VP Shunt
____	Bulimia	____	Genetic Disorders	____	Renal Disease
____	Cancer	____	Heart Murmur	____	Seasonal Allergies
____	Cerebral Palsy	____	High Cholesterol	____	Urological Problems
____	Chicken Pox	____	HIV/AIDS	____	Anxiety
____	Wears glasses/contacts	____	Hypertension	____	Depression
____	Smoking/Vaping	____	Alcohol/Substance Use	____	Mental Health Problems

Other: _____

ALLERGIES: _____

MEDICATIONS: _____

Pharmacy of Choice: _____ City: _____

Are immunizations up to date? YES / NO Who does the child live with? _____

Family History		Relation	Description
Cancer	☐ Yes ☐ No		
Neurological Problems	☐ Yes ☐ No		
Cardiac Disorders	☐ Yes ☐ No		
GI Disorders	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Mental Health Problems	☐ Yes ☐ No		
Alcohol/Substance Use Disorders	☐ Yes ☐ No		
Respiratory Disease	☐ Yes ☐ No		
Renal Disease	☐ Yes ☐ No		
Blood Disorders	☐ Yes ☐ No		
MS Disorders	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Surgeries: Date

_____ _____

_____ _____

Life Events (Examples: Accidents, Stroke, Heart Attacks): Date

_____ _____

_____ _____

I, the undersigned, do acknowledge I have completed this form honestly and to the best of my knowledge.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

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PRAPARE SURVEY

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Please complete this assessment specific to the patient.

Patient Name: _____ Date of birth: _____Date: _____

Address: _____

Housing & Income

1. What is your housing situation today?
   - ❑ I have housing
   - ❑ I do not have housing (staying with others, in a hotel, shelter, street, car, park, etc)
   - ❑ I choose not to answer

2. Are you worried about losing your housing?
   - ❑ Yes ❑ No
   - ❑ I choose not to answer

3. Household Size:
   - _____ Total Number of family members
   - ❑ I choose not to answer

4. Estimated annual household income
   - Income: $_____

Material Security

5. In the past year, have you or any family members you live with been **unable** to get any of the following when it was really needed?
   - Unable to get food
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
   - Unable to get clothing
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
   - Unable to get utilities
     - ❑ Yes ❑ No
     - ❑ I choose not to answer
6. Unable to get child care
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
7. Unable to get medicine or any health care (medical, dental, mental health, vision)
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
8. Unable to get phone service
   - ❑ Yes ❑ No
   - ❑ I choose not to answer
9. Unable to get housing or housing repair
   - ❑ Yes ❑ No
   - ❑ I choose not to answer

Insurance

10. What is your main insurance?
    - ❑ None/Uninsured ❑ Private insurance
    - ❑ CHIP Medicaid ❑ Medicaid
    - ❑ Other public insurance (CHIP) ❑ Medicare
    - ❑ Other public insurance (not CHIP)

Transportation/Isolation

11. Has lack of transportation kept you from appointments, meetings, work, or from daily living needs?
    - ❑ Yes, it has kept me from appointments/medications
    - ❑ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
    - ❑ No lack of transportation
    - ❑ I choose not to answer

12. How often do you see or talk to people that you care about and feel close to?
    - ❑ Less than once a week
    - ❑ 1-2 times a week
    - ❑ 3-5 times a week
    - ❑ 5 or more times a week
    - ❑ I choose not to answer

Violence/Stress

13. Do you feel physically and emotionally safe where you currently live?
    - ❑ Yes ❑ No
    - ❑ I choose not to answer
14. In the past year, have you been afraid of your partner or ex-partner?
    - ❑ Yes ❑ No ❑ Unsure
    - ❑ I have not had a partner in the past year
    - ❑ I choose not to answer
15. How stressed are you?
    - ❑ Not at all ❑ Quite a bit
    - ❑ A little bit ❑ Very much
    - ❑ Somewhat ❑ I choose not to answer

Employment/Education

16. What is your current work situation?
    - ❑ Unemployed
    - ❑ Part-time or temporary work
    - ❑ Full-time work
    - ❑ Otherwise unemployed, but not seeking work (student, retired, disabled, unpaid primary care giver)
    - ❑ I choose not to answer

17. What is the highest level of school that you have finished?
    - ❑ Less than high school
    - ❑ More than high school
    - ❑ High school diploma/GED
    - ❑ I choose not to answer

Personal Characteristics

18. Which race(s) are you? Check all that apply.
    - ❑ Asian Indian
    - ❑ Native Hawaiian
    - ❑ Pacific Islander
    - ❑ Black/African American
    - ❑ White
    - ❑ American Indian/Alaskan Native
    - ❑ Chinese
    - ❑ Japanese
    - ❑ Korean
    - ❑ Vietnamese
    - ❑ Other Asian
    - ❑ Samoan
    - ❑ Other Pacific Islander
    - ❑ Guamanian or Chamorro
    - ❑ Filipino
    - ❑ More than one race
    - ❑ I choose not to answer
    - ❑ Other

    If other, (please write):_____

19. What Ethnicity are you?
    - ❑ Mexican, Mexican American or Chicano/a
    - ❑ Cuban
    - ❑ Puerto Rican
    - ❑ NOT Hispanic, Latino/a or Spanish Origin
    - ❑ Hispanic, Latino/a or Spanish Origin
    - ❑ I choose not to answer

20. What language are you most comfortable speaking?
    - ❑ English
    - ❑ Other (please write):_____
    - ❑ Requires an Interpreter:_____
    - ❑ I choose not to answer

Situational Characteristics

21. Have you served in the United States military, armed forces or uniformed services?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

22. In the past year, have you spent more than 2 nights in a row in a jail, prison, or juvenile correction facility?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

23. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

24. Are you a refugee?
    - ❑ Yes
    - ❑ No
    - ❑ I choose not to answer

Community Services

25. Do you need assistance with any of the following?

Renewal maintenance of MO Healthnet coverage/food stamps
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Application assistance
(social service organizations, Medicaid, etc)
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Budgeting/financial literacy
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Health/disease education
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

26. Are you currently a foster, kinship, or adoptive parent or child?
    - ❑ Parent
    - ❑ Child
    - ❑ No

27. If yes, do you need any of the following?

Foster child care/Respite care
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

Foster transition assistance/planning (change in placement, transitioning out of care, youth services and/or juvenile justice)
- ❑ Yes
- ❑ No
- ❑ I choose not to answer

28. Communication Issues?
    - ❑ Hard of Hearing
    - ❑ Legally Blind
    - ❑ Mute
    - ❑ Registered Service Animal
    - ❑ Uses TTD Phone
    - ❑ Prefers Forms/Read aloud
    - ❑ Difficulty Reading
    - ❑ None of the above
    - ❑ I choose not to answer

29. Our health center offers a Sliding Fee Discount Program to help reduce the cost of care based on household income and size. Would you like to apply for this program today?
    - ❑ Yes, I would like to apply
    - ❑ No, I decline at this time
    - ❑ Already Enrolled

30. Would you like an OCHC Community Health Worker (CHW) to help you with anything on this form?
    - ❑ Yes
    - ❑ No