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

OZARKS COMMUNITY HEALTH CENTER
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MINOR CONSENT

PATIENT NAME: _____ PATIENT DATE OF BIRTH:_____/_____/_____

Consent for Health Care and Payment Agreement for OCHC Services: MINOR
Ozarks Community Health Center

CONSENT FOR HEALTHCARE: MINOR

I consent to healthcare provided by OCHC. Healthcare includes medical evaluation and tests and treatments ordered by my physician or his/her assistants. Tests and treatments include medications, x-rays, blood tests, and other services. I understand that students are sometimes utilized by the facility and may participate in my care. I have the right to formulate advanced directives and to have clinic staff and practitioners who provide care in the clinic comply with these directives. I consent any photographs, videotapes, digital or other images that may be recorded to document my care. I understand these images will be stored in the same manner as my medical records and will only be released pursuant to the same process as my medical records.

My medical information may be a part of a centralized electronic medical record that will be available to any Citizens Memorial Healthcare credentialed physician to whom I present for healthcare. As appropriate to state and federal law, patient information requested by state and federal agencies or a requesting body will be released. The practice of medicine is not an exact science. No guarantees have been made to me about the results of tests or treatments.

PAYMENT AGREEMENT

I agree to be responsible for and pay all charges for goods and healthcare services I receive for OCHC. This includes any charges my insurance will not pay. I authorize my insurance (including Medicare and Medicaid) to pay OCHC for the good and healthcare services received by me at OCHC. I also authorize OCHC to file claims with my insurance companies on my behalf. If insurance is billed and pays, I will be billed for any remaining balance. I agree to pay OCHC the total charge of goods and healthcare services or remaining balance after insurance immediately when I receive the final bill. If I do not pay in full, or make payments as arranged, I agree to be responsible for all costs of collection, including attorney fees. I promise the information I gave to Medicare and/or Medicaid when I applied for payment for medical services is correct. I authorize the release of medical information as required for payment of clinic charges. I understand this release may include my employer, insurance carrier, worker's compensation, or welfare agency. By signing this consent, Court appointed guardians are not assuming liability to pay for goods and services except from patient's assets.

OUTSIDE SERVICES

I understand my physicians may order tests or treatments that are not included in clinic charges. For example, if I am x-rayed, I may receive a separate bill from the Doctor of Radiology after he interprets the x-ray. Independent contractors (not OCHC employees) may be used to provide some patient services. Certain lab tests that are performed in our clinic may be sent out to CMH or a reference lab for processing.

HEALTH INFORMATION EXCHANGE

OCHC Participates in one or more Health Information Exchanges ("HIE") and may electronically share your information for treatment, payment, and health care operation purposes with other participants in the HIE's. HIE's allow your health care providers, inside and outside the OCHC system, to access and use your information for treatment and other lawful purposes. Such information may include information related to mental health, HIV/AIDS, genetic information, STDs, and family planning information. If you do not opt-out of this exchange of information, OCHC may provide your information to the HIE's in accordance with applicable law. If you wish to opt-out of this exchange of information, please ask your registration clerk for the Opt-Out Form to sign. If you choose to opt-out, your information may not be available to other non-OCHC providers in a medical emergency.

I HAVE READ THIS CONSENT FOR HEALTH CARE AND PAYMENT AGREEMENT AND AGREE TO ITS TERMS. IF NOT THE PATIENT, I AM AUTHORIZED TO CONSENT TO HEALTH CARE FOR THIS PATIENT.

I, the parent or guardian of the child named below, authorize and give permission to the following named person to seek medical evaluation and treatment for my child at any time and that said persons shall have my full authority and stand in position in loco parent is (In the place of a parent)

CHILD'S NAME: _____

Name:_____ Name:_____

Name:_____ Name:_____

Parent or Legal Guardian:_____Date:_____ Time:_____

Witness:_____Title:_____ Date: _____ Time:_____

MSHSAA Preparticipation Physical Forms/Procedure

Medical History Form (Step 1): Issued to Student/Parent(s)/Guardian, Completed by Student/Parent(s)/Guardian, Taken to Healthcare Professional (MD/DO/ARNP/PA/DC), Retained by Healthcare Professional.

Note: If the student is under 18 years old, the Medical History questions are to be completed with assistance from parent(s)/guardian(s).

Note: The health care professional (MD/DO/ARNP/PA/DC) who completes the pre-participation examination (PPE) shall keep this Medical History form in the patient's files for their records.

This Medical History form is NOT returned to the school.

MEDICAL HISTORY	
Name:	Date of Birth:
Sex assigned at birth (F, M or intersex):	How do you identify your gender? (F, M or other):
List past and current medical conditions:	
Have you ever had surgery? If yes, list all past surgical procedures:	
Medicines and supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional):	
Do you have any allergies? If yes, please list all of your allergies (i.e., medicines, pollens, food, stinging insects):	

PATIENT HEALTH QUESTIONNAIRE VERSION 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems (Circle response).

	Not at All	Several Days	Over Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge:	**0**	**1**	**2**	**3**
Not being able to stop or control worrying:	**0**	**1**	**2**	**3**
Little interest or pleasure in doing things:	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless:	**0**	**1**	**2**	**3**

A sum of ≥3 is considered positive on either subscale (questions 1 and 2, or questions 3 and 4) for screening purposes.

(Medical History Continued – Next Page)

Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever ordered a test for your heart? (For example, electrocardiography (ECG) or echocardiography?		
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you, or does someone in your family, have sickle cell trait or disease?		
24. Have you ever had, or do you have, any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to, or has anyone recommended, that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

IF "YES," EXPLAIN ANSWERS HERE

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of Student:
Signature of Parent(s) or Guardian:
Date:

Preparticipation Physical Examination Form (PPE) (Step 2): Issued to Student/Parent(s)/Guardian, Taken to Healthcare Professional (MD/DO/ARNP/PA/DC), Retained by Healthcare Professional.

Note: This PPE form is the recommended PPE form intended for guiding the healthcare professional (MD/DO/ARNP/PA/DC) with the completion of a preparticipation physical evaluation.

Note: The health care professional (MD/DO/ARNP/PA/DC) who completes the pre-participation examination shall keep this PPE form in the patient's files for their records. **This PPE form is NOT returned to the school.**

PRE-PARTICIPATION PHYSICAL EXAMINATION

Name:		Date of Birth:
EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP) and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal • Hearing		
Lymph Nodes		
Heart* • Murmurs (auscultation standing, auscultation supine and +/- Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA) or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test and box drop or step drop test		

* Consider electrocardiography (ECG), echocardiogram, referral to cardiology for abnormal cardiac history or examination findings, or a combination of those.

Physician Reminders:

Consider additional questions on more-sensitive issues.

- Do you feel stressed out or under a lot of pressure?
- Do you ever feel sad, hopeless, depressed or anxious?
- Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff or dip?
- During the past 30 days, did you use chewing tobacco, snuff or dip?
- Do you drink alcohol or use any other drugs?
- Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat belt, use a helmet and use condoms?

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Proceed to next page for
Medical Eligibility Form

MSHSAA Medical Eligibility Form (Step 3):

Issued to Student/Parent(s)/Guardian, Taken to/Completed by Healthcare Professional (MD/DO/ARNP/PA/DC), Copy Retained by Healthcare Professional, Returned to School Administration.

Note: This Medical Eligibility form is the form to be used by a healthcare professional (MD/DO/ARNP/PA/DC) for granting a medical release for a student to participate in All Sports – Spirit – Marching Band after the completion of a preparticipation physical evaluation.

Note: The health care professional (MD/DO/ARNP/PA/DC) must complete this form, retain a copy in the patient's files for their records and issue this form to the student/parent.

This Medical Eligibility form MUST be returned to the school.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex assigned at birth (F,M, intersex) _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restrictions for two (2) years.**

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for two (2) years with recommendations for further evaluation or treatment of:** _____

_____

☐ **Medically eligible for all Sports-Spirit-Marching Band without restriction for less than two (2) years. Specify reasons and duration of approval:** _____

_____

☐ **Medically eligible for certain Sports-Spirit-Marching Band:** _____

☐ **NOT medically eligible for Sports-Spirit-Marching Band**

☐ **NOT medically eligible pending further evaluation:** _____

I have examined the above-named student and completed the pre-participation physical evaluation. Unless otherwise indicated, the student does not present apparent clinical contraindications to practice and participate in the sport(s) or activities as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the student (and parents/guardians).

Name of health care professional (Print/Type) _____ Date of Examination **/ /**

Signature of Healthcare Professional (MD/DO/PA/ARNP/DC): _____

Clinic Address _____ City _____ State _____ Zip _____

Telephone _____

Student's Physician _____

Student's Dentist _____