Date ____________

Montana's Medical Genetics Program

2755 Colonial Drive, PO Box 5539, Helena, MT 59604
(406) 444-7500 1-800-447-6614 FAX (406) 884-2088

SECTION 1: PATIENT INFORMATION

Demographic Information

Last Name ____

First Name ____________________________ Middle Initial ________

Birth Date _____________________________

Social Security # ________________________ Sex: ☐ Male ☐ Female

☐ Child (0-18) ☐ Adult

Mailing Address ____

City __________________ State ____________ Zip ____________

Phone #_______________________ Other Phone ________________

Email Address ____

Race - Check all that apply

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ Unknown
☐ White or Caucasian

General Information

Primary Care Physician __________________________

Preferred Language _____________________________

Needs Interpreter Yes No

Deaf/HoH? Yes No

Hearing-Visual needs ___________________________

Blind/Low Vision Yes No

Marital Status ________________________________

Employer ____________________________________

Employment Status _____________________________

Ethnicity - Check all that apply

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

SECTION 2: RESPONSIBLE PARTY (COMPLETE FOR MINORS)

With whom does the patient reside?

Name ____ Birth Date ____________

☐ Biological Parent ☐ Adoptive Parent ☐ Other _____________

Name ____ Birth Date ____________

☐ Biological Parent ☐ Adoptive Parent ☐ Other _____________

*If child resides in **foster care** please complete the following:*

Case Worker Name ___________________________ Mailing Address _______________________________________

Phone # ___________________________________ City/State/Zip ____

Foster Parent(s) ____________________________ Phone # (Foster) ______________________________________

~Please provide legal documentation of medical consent and guardianship for patient~

SECTION 3: INSURANCE INFORMATION (fill out completely & provide a copy of insurance card if possible)

Primary Insurance Co. Name ____

Name of Subscriber ____ Date of Birth of Subscriber ______________

Social Security # of Subscriber _____________________ ID # ____________________________ Group # __________________

Secondary Insurance ____

Name of Subscriber ____ Date of Birth of Subscriber ________________

Social Security # of Subscriber _________________ ID # _____________________ Group # ________________

Patient Name: ____ DOB: ______________

AUTHORIZATION FOR TREATMENT AND PAYMENT AGREEMENT

I hereby authorize the physician or physicians in charge of the care of the above patient to administer any outpatient treatment necessary or advisable in evaluation, diagnosis, and care of this patient. I understand that the physician may discover other or different conditions that require additional or different treatment than that currently anticipated. I authorize the physician and such other health care providers to administer such other treatment that is necessary or advisable in their professional judgment.

Shodair Children's Hospital staff care about the quality of service we provide to patients and families. Please provide us with your insurance information, be it private or through a government agency, and we would be glad to assist you in determining any financial obligations you might incur during the patient's treatment. If the patient is not covered by an insurance program, then our staff will provide you with information about other potential options that might exist, such as our program called ShoCare. If you qualify, this program provides financial assistance in the form of discounts and monthly interest-free payments. Our Financial Counselor will send you a program brochure with the first billing statement. Or you may request a brochure at any time by calling 406-444-4507.

Once insurance has been billed and the claim processed, or if you do not have any insurance, any balance due will become your responsibility. We encourage you to contact our Business Office at the number above to review payment options, including applying for the ShoCare program. In the event we do not hear from you to set up payment options, or a bill becomes tardy, your account may be sent to a third-party collection agency. (The collection agency may charge you for attorney fees, out-of-pocket costs of collections and interest on any unpaid balance.)

By signing below as the Responsible Person, you are acknowledging that you have read and agree with your responsibility to pay any balance after applicable insurance and/or government agencies have processed your claim and any discounts have been applied to your account.

Also by signing below as the Responsible Person, this Authorization and Payment Agreement allows the patient to participate in outpatient treatment described above.

RESPONSIBLE PERSON

____
Printed Name Relationship to Patient

____
Signature Date

SHODAIR CHILDREN'S HOSPITAL

____
Printed Name

____
Signature Date

PATIENT

____
Printed Name

____
Signature (if patient is 16 or older) Date

Department of Medical Genetics
Phone 406.444.1016 | **Fax** 406.884.2088
www.shodair.org | 800.447.6614 | 2755 Colonial Drive | Helena, MT 59601

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Medical Director, Laboratory Director
Laura Rear, DNP, APRN, FNP-C
Willow Sheehan, DNP, APRN, FNP-C

Jaclyn Haven, MS, CGC
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Katherine Berry, MS, CGC
Katie Seraji, MS

Corbin Schwanke
Administrative Director, Laboratory Supervisor
Tyler Setlock, RD
Christa Smelko, PsyD

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P.O. Box 5539
Helena, MT 59604
Phone: 406-444-7500
Fax: 406-884-2088

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that Shodair Hospital may share my health information for treatment, payment and healthcare operations. I have been given a copy of Shodair Hospital's Notice of Privacy Practices that describes how my health information is used and shared. I understand Shodair Hospital has the right to change this notice at any time. I may obtain a current copy by contacting Shodair Hospital.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices.

_______________________________________ ______________________

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship

to patient: ____________________________

Patient Name: ________________________________

Date of Birth: _____________

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Shodair CHILDREN'S HOSPITAL

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History Questionnaire

Completed by: __________ (staff)(patient) on: ___/___/___

NAME: ____ (Male) (Female) Age: _____ DOB: __________

ETHNICITY (check): ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other ☐Refused

REVIEW OF SYSTEMS ***Positive Response = Circle***

- **Any history of:** (Constitutional symptoms)
  Developmental Delay   Change in weight   School difficulties
- **Do you have:** (Skin)
  Unusual healing   Spots (brown, white, red)   Bumps
- **Have you recently had:** (All/mm)
  Severe Allergies   Frequent infections
- **Have you recently had:** (Ears/nose/mouth/throat)
  Hearing loss   Difficulty swallowing/reflux   Difficulty sleeping   Snoring
- **Have you recently had:** (Eyes/head)
  Visual problems   Severe headache   Small/large head
- **Do you have:** (Respiratory)
  Shortness of breath   Frequent coughs   Wheezing
- **Do you have:** (CV)
  Chest pain   Murmur   Congenital heart defect
- **Do you have:** (GI)
  Vomiting   Abdominal pain   Change in bowel habits   Diarrhea   Constipation
- **Do you have:** (GU)
  Problems with urination   Genital birth defects   Urine infections   Menstruation   Irregular periods (if applicable)
- **Do you have:** (Endo)
  Thyroid problems   Absent/excess body hair   Unusual body odor
- **Do you have:** (Musculoskeletal)
  Loose joints   Pain in joints   Stiffness   Scoliosis   Broken bones   Muscle weakness
- **Do you have:** (Neuro)
  Attention problems   Speech problems   Seizures   Balance problems
- **Do you have:** (Psych)
  Anxiety   Depression   Mood swings   Problems with drugs/alcohol
- **Do you have:** (Heme/lymph)
  Bruise easily   Bleeding problems   Puffy hands/feet
- **Do you have any other signs, symptoms, or problems other than above?** No_____ Yes______ Please explain: