**PATIENT REGISTRATION / INFORMATION SHEET**

Name:

LAST FIRST MIDDLE

Date of Birth:

My current gender identity is O Male O Female O Transgender Female / Transgender Woman O Transgender Male/ Transgender Man O Two-spirit O Genderqueer / Gender Fluid O Intersex

O Non-binary/Gender Non-Conforming O Another identity: \_\_\_\_\_\_\_\_\_\_\_\_\_O Decline to answer.

My sex assigned at birth is O Male O Female O Non-Binary O Not designated on birth certificate O Decline to answer.

My sexual orientation is O Straight O Lesbian O Gay O Bisexual O Pansexual O Queer O Asexual O Questioning

O Another identity: \_\_\_\_\_\_\_\_\_\_\_\_\_O Decline to answer

My pronouns are O He/him/his O She/her/hers O They/them/theirs O Ze/hir O Another pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:

Social Security Number: Street Address: Home Phone: Work Phone:

Email Address\*: City: State: Zip: Cell Phone: Primary Language:

Race: American Indian Asian African American Native Hawaiian White Other Unknown

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Religious Preference (optional):

\*By providing your email address, you are electing to receive email communication from our practice.

Employment Status:

Employer: Street Address: Date of Retirement (if applicable):

Emergency Contact: Street Address: Home Phone: Work Phone:

Occupation: City: State: Zip: Spouse’s Date of Retirement (for Medicare patients):

Relationship: City: State: Zip: Cell Phone:

I hereby give my permission to contact the above-mentioned individual if I cannot be reached. I further give my permission for any treating physician or physician’s representative to speak with this person regarding me or my medical condition including but not limited to lab/pathology/diagnostic test results. Yes No

Primary Insurance: HMO POS/PPO Medicare Cash Other: Insurance Company Name: Group #: Policy/ID#:

Secondary Insurance: HMO POS/PPO Medicare Cash Other: Insurance Company Name: Group #: Policy/ID#:

Primary Insurance Subscriber: Date of Birth: Employment Status:

Relationship: Social Security Number: Employer:

Job Title:

Street Address:

City: State: Zip:

Referring Physician:

Other Treating Physician:

Patient/Legal Representative: Date/Time: If signed by other than patient, indicate relationship:

Print Name – Legal Representative:

**AUTHORIZATION TO SHARE PATIENT INFORMATION**

Name:

LAST FIRST MIDDLE

Date of Birth:

**Phone Messages**

Is there a phone number where the medical office can call and leave detailed messages regarding your care, appointment/health screening reminders and other health care messages?

Yes No If yes, please provide phone number:

**Text Messages**

Do you wish to receive appointment/health screening reminders and other health care messages via text?

Yes No

If yes, please provide preferred phone number to receive text messages:

**E-Mail**

Do you wish to receive appointment/health screening reminder and other health care messages via e-mail?

Yes No

If yes, please provide preferred e-mail address:

**Additional Contact**

Is there someone else who the medical office can leave detailed **messages** with and share your patient information?

Yes No If yes, please provide:

Name:

Relationship to Patient:

Phone Number:

I hereby consent to receiving messages as indicated above from the medical office listed. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying “STOP” to the text message from my mobile device.

The Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient.

Patient/Legal Representative Signature: Date: Time: AM/PM If signed by other than patient, indicate relationship: Print Name – Legal Representative:

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that the medical office selected above, and affiliates may share my health information for treatment, billing, and healthcare operations. I have been provided a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that the entity selected above, and affiliates has the right to change this notice at any time. I may obtain an additional copy by contacting my provider’s office selected above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient Name:

Signature: Date:

PATIENT / LEGAL REPRESENTATIVE

If signed by other than patient, indicate relationship to patient:

**INABILITY TO OBTAIN ACKNOWLEDGMENT**

Complete only if no signature is obtained. If it is not possible to obtain the individual’s acknowledgment, describe the good faith efforts made to obtain the individual’s acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

Patient or Legal Representative received Notice of Privacy Practices but refused to sign

Acknowledgment of Receipt

Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices

Other:

Patient Name:

Staff Signature: Date:

**HEALTH HISTORY**

Name:

Date of Birth:

Date:

Reason for Today’s Visit:

Previous Primary Care Physician: Current Specialists:

Phone Number:

1) Name:

2) Name:

Specialty: Phone Number: Specialty: Phone Number:

Note: If you are currently seeing more specialists than the space above allows, please list the additional specialists on the back of this form.

**Allergies**: Any known drug allergies? Yes No

Please list all allergies including food, medications and environmental and reaction.

**Do you currently take any medications on a regular basis?** Yes No

If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

**MEDICAL HISTORY**

**Illness and Conditions** - Do you have or have you ever had any of the following:

Year:

Have you had any past medical problems?

Yes No If yes, list below:

Alcoholism Anxiety Anemia Arthritis Asthma

Bleeding Problems Have you had any previous surgeries or hospitalizations?

Birth Defects Cancer, Type: Colitis Concussion

Depression/Nervous Breakdown

Diabetes

Emphysema

Yes No If yes, list details and date below:

Year:

GERD/Heartburn/Reflux **Childhood Diseases** Year: Gout Chicken Pox

Heart Attack/Heart Disease Measles

High Blood Pressure Mumps High Cholesterol Polio Kidney Disease Other: Lupus

Liver Disease/Hepatitis **Gynecological History (women only)**

Migraine Headache Last Menstrual Period

Mitral Valve Prolapse/Murmur How many pregnancies have you had?

Osteoporosis How many children do you have?

Prostate Enlargement (BPH) Have you ever had an abnormal pap smear?

Rheumatoid Arthritis Have you had a hysterectomy?

Seizure Disorder Have your ovaries been removed?

Sexually Transmitted Disease

Skin Problems **Sexual History**

Stroke Do you have sex with: Men Women Both

Thyroid Disease Have you had an HIV Test? Yes No

Tuberculosis Do you use condoms for sexual intercourse? Yes No

Other:

**FAMILY HISTORY**

Do you have any family history of serious illness? Yes No

If yes, list below:

Mother Father Grandparent Living Age Deceased Age at Death and Cause

Alcoholism Father Asthma Mother Bleeding Problems Brother Cancer, Type:

Diabetes

Emphysema

Glaucoma Sister

Heart Attack

Heart Disease

High Blood Pressure Son

Mental Illness/Suicide

Osteoporosis

Seizures Daughter

Stroke

Thyroid

**HEALTH MAINTENANCE**

When did you last have any of the following? List year of Last Vaccinations:

Diabetes Check Pap Smear Tetanus (TD) Hepatitis A Prostate Check Cholesterol Check Influenza (Flu) Hepatitis B Colonoscopy Cardiac Stress Test Pneumonia HPV Mammogram Bone Density Shingles (VZV) TB Skin Test

**SOCIAL HISTORY**

Marital Status: Single Married Partnered Co-Habiting Separated Divorced Widowed

Do you have children/dependents at home? Yes No How many?

Are you employed? Yes No Occupation:

What is your highest level of education? High School College Graduate School

Do you or have you ever smoked or chewed tobacco? Yes No When? Quit Date: Packs/ Cans/ Bags per day: / years:

Do you or have you ever used recreational drugs? Yes No Type: How often?

Do you drink alcohol? Yes No Type: How often? How much per day? / Years

Have you ever been exposed to toxic substances? Do you drink caffeine?

|  |  |  |
| --- | --- | --- |
| Yes  Yes | No  No | Type: What kind?  Type: How often? |
| Yes  Yes  Yes | No  No  No | Type: How often? |
| Yes | No |  |

Do you exercise?

Do you wear a seatbelt?

Do you use car seats for your children if under 60 lbs.? Do you have a living will or advance directives?

**Patient Signature: Date/Time:**

**CONDITIONS OF TREATMENT**

Name:

LAST FIRST MIDDLE

Date of Birth:

**Consent to Treatment**

I hereby consent to all health care treatment and procedures provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Such treatment and procedures may include diagnostic, therapeutic, imaging, and laboratory services.

**Financial Responsibility**

I hereby assign and authorize direct payment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment. I hereby attest that the insurance information provided to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is accurate, and that I am an eligible member. I understand that I am responsible for knowing my benefits / coverage and acknowledge that tests ordered by my physician may NOT be covered by my insurance company.

I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I hereby authorize the release of all information to other physicians and insurance carriers for the purpose of payment for medical services, and further treatment of care by another physician. I further agree that a photocopy of this form shall be as valid as the original.

Payment is due at the time services are rendered. All charges are my direct responsibility. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cannot render medical services on the assumption that the charges will be paid by my insurance company. If \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has problems collecting payment from me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will also add attorney’s fees, collection agency costs and any related fees to my bill.

**Patient Portal (REMOVE IF NO PATIENT PORTAL)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ utilizes a Patient Portal, which allows me to electronically access my medical information. By signing this form, I hereby request and agree that my medical information and laboratory test results may be provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that, unless certain conditions are satisfied, the laboratory test results made available through the Patient Portal will not include test results for HIV, hepatitis, drug abuse, or routinely processed tissues.

**By signing below, I acknowledge that I have carefully read, understand, and agree to the terms of this**

**Conditions of Treatment.**

Patient/Legal Representative Signature: Date: Time: If signed by other than patient, indicate relationship: Print Name (Legal Representative):