Today's Date ____/____/____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?		Birthdate / /	Age Sex ☐ M ☐ F ☐ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military
Student Status: ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Other ☐Declined

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language: ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

Pharmacy: Do you have a living will? ☐ YES ☐ NO

Referred By (Please check one box)
☐ Dr. _____ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐Yellow Pages ☐ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐Another Patient ☐Guarantor ☐Self ☐Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )
Occupation / Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC)
☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE _____

Does the patient have healthcare coverage? ☐ YES ☐ NO **Insurance Name**

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number)
	- -	/ /	/ /		

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number)
		/ /		

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number	Other Phone Number
		( )	( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date

Personal Health History

Provider initials: _____

Patients Name_____Date:_____Date of Birth _____

Previous Primary Care Doctor's Name:

_____

Office Name:

_____

City: _____ State: _____

List any specialists that you see:

Name	Specialty

Allergies

Medication/Food/Other	Reaction

Childhood Diseases: Have you had the following diseases?

	Yes	No
Chicken Pox		
Mono		
Measles		
Mumps		
Other (Please Specify)		

Surgeries: Mark those that you have had in the past

	Yes	Approximate Date	Comments
Appendectomy			
Gallbladder			
Endoscopy (Upper)			
Colonoscopy			
Hernia Repair			
C-Section			
Heart Catherization			
Tubal Ligation			
Hysterectomy / Vasectomy			

Tonsillectomy			
Other			
Other			
Other			

Name_____ Date of Birth _____

Have you ever been hospitalized?

_____ **YES** _____ **NO**

Yes	Approximate Date	Comments

Do you smoke?: _____ Yes _____ No

Did you ever smoke?: _____ Yes _____ No

When did you quit?: _____

How many packs a day?: _____ Yes _____ No

Do you ever drink alcohol?: _____ Yes _____ No

How often do you drink?: _____

When you do drink, how many drinks do you consume?: _____

OB/GYN History (Females Only)

Total # Of Pregnancies: _____ Total # of Live Births: _____

Abortions: _____ Miscarriages: _____ Last Pap Smear: _____

Last Mammogram: _____

Last Bone Density Screening: _____

Last PSA Test (Men Only): _____

Last Flu Shot: _____Last pneumonia shot: _____ Last Tetanus shot: _____

Personal Information:

Who do you live with?

_____

Do you feel safe in your home? _____Yes _____No

Have you fallen in the last three months? _____Yes _____No

Do you ever use a cane, walker, or other assistive device? _____Yes_____No

Please check, if you currently have any of the following:

General
- ○ Chills
- ○ Fatigue
- ○ Fever

Eyes
- ○ Eye pain
- ○ Decreased vision
- ○ Eye injury
- ○ Floaters

Ears, Nose, Throat
- ○ Dental Pain
- ○ Ear Pain
- ○ Hearing Loss
- ○ Sinus problems
- ○ Snoring

Respiratory
- ○ Shortness of breath
- ○ Cough
- ○ Shortness of breath on Exertion

Cardiovascular
- ○ Chest pain
- ○ Irregular Heart beat
- ○ Swelling in legs

Gastrointestinal
- ○ Abdominal pain
- ○ Blood in stool
- ○ Constipation
- ○ Diarrhea
- ○ Heartburn

Genitourinary
- ○ Blood in urine
- ○ Burning with urination

Musculoskeletal
- ○ Arthritis
- ○ Back pain
- ○ Joint pain
- ○ Muscle weakness
- ○ Shooting arm pain
- ○ Shooting leg pain

Skin
- ○ Moles
- ○ Rash
- ○ Skin sores or ulcers

Neurologic
- ○ Loss of Balance
- ○ Memory loss
- ○ Migraines
- ○ Speech slurring
- ○ Numbness/tingling
- ○ Loss of sensation

Psychiatric
- ○ Suicidal Thoughts
- ○ Depression
- ○ Anxiety/worry
- ○ High stress level
- ○ Panic attacks
- ○ Sleep disturbance

Endocrine
- ○ Thyroid problems
- ○ Weight gain
- ○ Weight loss

Allergic/Immunologic
- ○ Allergies

Hematologic/Lymphatic
- ○ Bleeding easily
- ○ Blood clots

Female Reproductive
- ○ Breast tenderness
- ○ Hot flashes
- ○ Nipple discharge
- ○ Vaginal discharge
- ○ Recent STD

Male Reproductive
- ○ Ejaculation difficulty
- ○ Erection difficulty
- ○ Penile pain
- ○ Testicular pain
- ○ Recent STD

For all new patients and any annual physical/well woman exam.

Name_____ Date of Birth _____

Personal and Family Medical History

Do you or your family have any of the following? (Check those that apply)

	You	Family Member	Comments
Alcoholism			
Anemia			
Asthma			
Cancer (specify type)			
COPD			
Diabetes			
Depression			
Heart Disease			
High Blood Pressure			
High Cholesterol			
HIV / AIDS			
Joint Problems			
Kidney Disease			
Migraines			
Seizures			
Sickle Cell			
Substance Abuse			
Thyroid Problems			
Other			
Other			

Current Medications

Patients Name _____

Please list below any prescription and over the counter medicines you take on a regular basis.

Name of Medicine	Dosage	Route	Frequency	Special Instructions
	(how many mgs, IU, units, etc)	(oral, rectum, transdermal patch, cream, ointment)	(every am, pm, 2x per day, 3x per day)	(liquid medicine, mix with another medicine)

LABS

EACH YEAR BEFORE YOU HAVE LABS DRAWN, IT IS RECOMMENDED YOU CHECK WITH YOUR INSURANCE COMPANY TO BE SURE PERSON MEMORIAL HOSPITAL IS THE PREFERRED LAB. OTHERWISE, YOUR OUT OF POCKET COSTS MAY BE HIGHER.

PERSON PRIMARY CARE

PRACTICE NAME

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or

behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

Person Health Primary Care

Appointment No-Show Policy

- Any patient who fails to arrive for a scheduled appointment without cancelling the appointment is considered a no-show.
- We ask that patients give at least a 24 hour notice for any appointments that are cancelled or rescheduled. Patients who fail to cancel or reschedule more than 24 hours prior to the appointment will be considered a no-show.
- The patient will be charged $15.00 for each no-show appointments. This is billed directly to the patient.
- A patient who fails to present for his or her appointment more than twice is considered a chronic no-show. A chronic no-show patient is only given certain appointment slots (e.g. the last appointment of the morning)
- A patient who fails to show for their appointment more than three times will be dismissed from the practice.

I understand the no-show policy of DLP Person Physician Practices, LLC.

_____

Patient or Guardian Signature

_____