



PATIENT REGISTRATION

**CHERISH
HEALTH
CLINIC**
 Dr. Carol Alley, M.D.

Patient Information			
Patient Name: (Last, First, Middle Initial)	Gender:	Date of Birth:	Social Security #:
Address: (Street, Apt, City, State, zip)			
Home Phone:	Work Phone:	Cell Phone:	Email:
Employer:	Occupation:		Emergency Contact Name:
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Partnered x _____ years			Emergency Contact Phone:
Who completed this form? <input type="radio"/> Patient <input type="radio"/> Family Member (<i>Parent, sibling etc.</i>) _____ <input type="radio"/> Partner <input type="radio"/> Guardian			Emergency Contact Relationship:
How would you like to be contacted? <input type="radio"/> Home Phone <input type="radio"/> Cell Phone <input type="radio"/> Work Phone <input type="radio"/> Email <input type="radio"/> Voicemail		How did you hear about us?	
Insurance Information			
Primary Insurance:		Secondary Insurance:	
ID#:	Group#:	ID#:	Group#:
Name of person responsible for the account:	Phone:	Relationship to patient:	
Health Provider Information			
Name of primary care physician or medical provider:		Date last seen:	Phone number:
Address:			Fax number:
Current Medications			
Medication name, dosage, and reason for taking:		Medication name, dosage and reason for taking:	
Medication name, dosage and reason for taking:		Medication name, dosage and reason for taking:	
Medication name, dosage and reason for taking:		Medication name, dosage, and reason for taking:	

Social History

Do you drink alcohol? <input type="radio"/> No alcohol use <input type="radio"/> Less than 2 drinks weekly <input type="radio"/> 1-2 drinks daily <input type="radio"/> More than 2 drinks daily	Do you use recreational drugs? Type: _____ Frequency: _____	Do you use tobacco products? Type: _____ Frequency: _____ <input type="radio"/> Former Smoker
Do you feel safe at home? <input type="radio"/> Yes <input type="radio"/> No	Do you live alone? <input type="radio"/> Yes <input type="radio"/> No	Do you drink caffeinated beverages? Frequency: _____

Family History (check all that apply)

	Mother	Father	Brother	Sister	Other		Mother	Father	Brother	Sister	Other
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mental Illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please provide details or list other chronic conditions:

Past Hospitalizations/Surgeries/Where Performed

1.	Date:	2.	Date:
3.	Date:	4.	Date:

Allergies

(check) I have no known drug allergies

I am allergic to:	I have the following reaction:	I am allergic to:	I have the following reaction:
1.		3.	
2.		4.	

Female Patients

Date of last pelvic exam:	Date of last pap smear:	Abnormal pap smear? <input type="radio"/> Yes <input type="radio"/> No	No. of Pregnancies?
Date of last mammogram:	Date last menstrual period onset:	Possibly pregnant? <input type="radio"/> Yes <input type="radio"/> No	Colonoscopy? <input type="radio"/> Yes <input type="radio"/> No

Male Patients

Date of last prostate exam:	Abnormal prostate exam: <input type="radio"/> Yes <input type="radio"/> No	Colonoscopy? <input type="radio"/> Yes <input type="radio"/> No
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Immunizations/Vaccines (indicate date if known)

	Influenza	Hep B	Hep A	Measles	BCG or Pos PPD	Tetanus	Polio	Shingles	Pneumonia
Yes									
No									
Not Sure									

Health History

Please indicate conditions you presently have OR have had in the past. N = NOW P = PAST:

<p>Cancer</p> <p>Type:</p> <p>Cardiovascular Problems</p> <p>___ stroke</p> <p>___ chest pain</p> <p>___ irregular heartbeat</p> <p>___ high blood pressure</p> <p>___ hardening arteries</p> <p>___ heart murmur</p> <p>___ other heart condition</p> <p>Neurologic Problems</p> <p>___ headaches</p> <p>___ head injury</p> <p>___ convulsions/seizures</p> <p>___ paralysis of limbs</p> <p>___ multiple sclerosis</p> <p>Ears, Nose, Mouth, Throat</p> <p>___ ear trouble</p> <p>___ decreased hearing</p> <p>___ sinus trouble</p> <p>___ strep throat history</p>	<p>Gastrointestinal</p> <p>___ stomach</p> <p>___ acid reflux GERD</p> <p>___ diverticulitis</p> <p>___ colitis/Crohn's</p> <p>___ other bowel problems</p> <p>___ liver trouble</p> <p>___ gall bladder trouble</p> <p>___ hernia</p> <p>___ hemorrhoids</p> <p>Skin Problems</p> <p>___ skin infections</p> <p>___ skin lesions</p> <p>___ eczema</p> <p>___ psoriasis</p> <p>___ recent tattoos</p> <p>___ other</p> <p>Endocrine</p> <p>___ thyroid disease</p> <p>___ diabetes</p> <p>___ insulin dependent</p>	<p>Respiratory</p> <p>___ shortness of breath</p> <p>___ bronchitis</p> <p>___ emphysema/COPD</p> <p>___ pneumonia</p> <p>___ allergies</p> <p>___ asthma</p> <p>___ tuberculosis or exposure</p> <p>___ other lung problems:</p> <hr/> <p>Eyes</p> <p>___ wear glasses/contacts</p> <p>___ eye or eye lid infection</p> <p>___ glaucoma</p> <p>___ other eye problems</p> <p>Musculoskeletal</p> <p>___ arthritis</p> <p>___ rheumatoid arthritis</p> <p>___ bone/joint infection</p> <p>___ artificial joint</p> <p>___ bone tumor/cyst</p> <p>___ gout</p>	<p>Genitourinary</p> <p>___ kidney disease</p> <p>___ prostate</p> <p>___ bladder disease</p> <p>___ gonorrhea, syphilis, herpes (please circle)</p> <p>___ loss of bowel or Bladder control</p> <p>Hematologic/Lymphatic</p> <p>___ bleeding/bruising</p> <p>___ blood clotting prblms.</p> <p>___ anemia</p> <p>___ phlebitis</p> <p>___ hepatitis</p> <p>Type _____</p> <p>Psychiatric</p> <p>___ mental problems</p> <p>___ nervous breakdown</p> <p>___ depression</p> <p>___ bipolar</p> <p>___ other</p> <hr/> <p>Other</p> <p>___ migraines</p> <p>___ HIV</p> <p>___ Lupus</p>
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Patient Consent for Services, Use and Disclosure of Protected Health Information

I CONSENT (AGREE) TO MEDICAL SERVICES: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I will ask for any information I want to have about my services and will make my wishes known to the practitioners and/or staff.

I hereby give my consent for **Creekside Health Clinic, Inc and Cherish Health Clinic** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Creekside Health Clinic, Inc and Cherish Health Clinic** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Creekside Health Clinic, Inc and Cherish Health Clinic** reserve the right to revise its Notice of Privacy Practices at any time.

With this consent, **Creekside Health Clinic, Inc and Cherish Health Clinic** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Creekside Health Clinic, Inc and Cherish Health Clinic** may send e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Creekside Health Clinic, Inc and Cherish Health Clinic** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Creekside Health Clinic, Inc and Cherish Health Clinic** may decline to provide treatment to me.

By signing below, I am confirming that I understand the information above and that I consent to the disclosures described.

Patient Name

Signature

Date

If signed by anyone other than the patient, please indicate which of the following describes the relationship to the patient:

Parent/Guardian Health Care Agent Other _____

Notice of Privacy Practices: I acknowledge that I have received the Clinic's Notice of Privacy Practices

Clinic Payment Policy

IF YOU ARE COVERED BY INSURANCE:

Our office is currently participating in Medicaid, Medicare as well as many local, state and federal insurance programs. You must present your insurance identification card at the time of the visit. We will file the claims for you. However, you are responsible for the annual deductible and co-payment as required by your insurance plan. ***WE WILL REQUIRE THAT YOU PAY THE CO-PAYMENT AND ANNUAL DEDUCTIBLE PRIOR TO YOUR OFFICE VISIT.*** If you do not have your insurance card with you at the time of your visit, you will be considered a cash pay patient.

IF YOU ARE NOT COVERED BY INSURANCE:

We understand that many patients may not be covered by any type of medical insurance. In order for this clinic to keep costs reasonable while giving you excellent health care, payment is required at the time of service unless prior arrangements have been made. For your convenience we take major credit cards, credit/debit cards, checks and cash. There is a \$50 fee for all returned checks. Returned checks must be recovered within 10 days or the patient may be denied future services from this clinic. If a check is returned for non-sufficient funds more than once by a patient/guarantor then payment will only be accepted by cash or credit card.

CREDIT & COLLECTION POLICY:

At this time **Creekside Health Clinic, Inc and Cherish Health Clinic** requires that payment be made at the time of service unless prior arrangements have been made. We will do our utmost in keeping you informed of your health care costs as services are rendered. If there is balance on your account after your insurance carrier has been billed, you will be responsible for payment on your account in a timely manner. Balances not paid after 90 days will be subject to collection and legal services and health services from this clinic may be denied until the account is no longer delinquent.

MISSED APPOINTMENTS:

In the event that you are unable to keep a previously scheduled appointment, it is our expectation that you will call the clinic prior to your scheduled time. Otherwise the clinic reserves the right to charge your account **\$50.00** which will need to be paid prior to scheduling additional appointments.

By signing below, I am confirming that I understand the information above.

Patient Name

Signature

Date