PATIENT REGISTRATION

Patient Information

Patient Name: (Last, First, Middle Initial)	Gender:	Date of Birth:	Social Security #:
Mailing Address: (Street / Apt. / PO Box)	City	State	Zip Code

Home Phone:	Work Phone:	Cell Phone:	Email:

Employer:	Occupation:	Emergency Contact Name:
Marital Status: O Single O Married O Separated O Divorced O Partnered x _____ years		Emergency Contact Phone:
Who completed this form? O Patient O Family Member (*Parent,sibling etc.)* _____ O Partner O Guardian		Emergency Contact Relationship:
How would you like to be contacted? O Home Phone O Cell Phone O Work Phone O Email O 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?	Do you use recreational drugs?	Do you use tobacco products?
O No alcohol use O Less than 2 drinks weekly O 1-2 drinks daily O More than 2 drinks daily	Type:_____ Frequency:_____	Type:_____ Frequency:_____ O Former Smoker
Do you feel safe at home?	Do you live alone?	Do you drink caffeinated beverages?
O Yes O No	O Yes O No	Frequency:_____

Family History (check all that apply)

	Mother	Father	Brother	Sister	Other		Mother	Father	Brother	Sister	Other
Diabetes	O	O	O	O	O	Thyroid Disease	O	O	O	O	O
Heart Disease	O	O	O	O	O	Arthritis	O	O	O	O	O
Stroke	O	O	O	O	O	Mental Illness	O	O	O	O	O
Cancer	O	O	O	O	O	Asthma	O	O	O	O	O
High Blood Pressure	O	O	O	O	O	Other	O	O	O	O	O

Please provide details or list other chronic conditions:

Past Hospitalizations/Surgeries/Where Performed

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

Allergies

O (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? O Yes O No	No. of Pregnancies?
Date of last mammogram:	Date last menstrual period onset:	Possibly pregnant? O Yes O No	Colonoscopy? O Yes O No

Male Patients

Date of last prostate exam:	Abnormal prostate exam: O Yes O No	Colonoscopy? O Yes O No

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:

Cancer

Type:

Cardiovascular Problems

___ stroke
___ chest pain
___ irregular heartbeat
___ high blood pressure
___ hardening arteries
___ heart murmur
___ other heart condition

Neurologic Problems

___ headaches
___ head injury
___ convulsions/seizures
___ paralysis of limbs
___ multiple sclerosis

Ears, Nose, Mouth, Throat

___ ear trouble
___ decreased hearing
___ sinus trouble
___ strep throat history

Gastrointestinal

___ stomach
___ acid reflux GERD
___ diverticulitis
___ colitis/Crohn's
___ other bowel problems
___ liver trouble
___ gall bladder trouble
___ hernia
___ hemorrhoids

Skin Problems

___ skin infections
___ skin lesions
___ eczema
___ psoriasis
___ recent tattoos
___ other

Endocrine

___ thyroid disease
___ diabetes
___ insulin dependent

Respiratory

___ shortness of breath
___ bronchitis
___ emphysema/COPD
___ pneumonia
___ allergies
___ asthma
___ tuberculosis or exposure
___ other lung problems:
_____

Eyes

___ wear glasses/contacts
___ eye or eye lid infection
___ glaucoma
___ other eye problems

Musculoskeletal

___ arthritis
___ rheumatoid arthritis
___ bone/joint infection
___ artificial joint
___ bone tumor/cyst
___ gout

Genitourinary

___ kidney disease
___ prostate
___ bladder disease
___ gonorrhea, syphilis, herpes (please circle)
___ loss of bowel or Bladder control

Hematologic/Lymphatic

___ bleeding/bruising
___ blood clotting prblms.
___ anemia
___ phlebitis
___ hepatitis
Type_____

Psychiatric

___ mental problems
___ nervous breakdown
___ depression
___ bipolar
___ other
_____

Other

___ migraines
___ HIV
___ Lupus

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** 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** 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** reserve the right to revise its Notice of Privacy Practices at any time.

With this consent, **Creekside Health Clinic, Inc** 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** 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** 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** 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** 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