Saint Alphonsus Medical Group

PATIENT REGISTRATION: PATIENTS 18 YEARS AND OLDER

Date: _____

Patient

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Gender: ☐ Female ☐ Male Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell) _____

Phone (Work) _____ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

Employer _____

Employer Address _____ City _____ State _____ Zip _____

Have you been seen at a St Alphonsus Clinic or Express Care Clinic in the past 3 years? ☐ Yes ☐ No

Who is your current / past primary care provider? _____

Preferred Pharmacy_____ Major Crossroads _____

Health Insurance
(Clinic: If unable to scan card, make copy and attach. If card unavailable, write info on this form.)

Primary Insurance _____ ***(Employer ONLY needed if different from above.)***

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Additional Contact (not living with you)

Last Name _____ First Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

Advanced Directives (Living Will)

Would you like more information about Advance Directives? ☐ Yes ☐ No

Brochure Provided? ☐ Yes ☐ No

People assisting with paperwork:

Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____

Complete both pages

Saint Alphonsus Medical Group

Today's date:_____

ANNUAL HEALTH HISTORY

Name:_____ Age:_____ Date of last physical exam: _____

Health Review: Have you had or are you now having any of the following symptoms?

GENERAL CONSTITUTION
__ Appetite decreased
__ Appetite increased
__ Chills/Rigors
__ Dizziness
__ Fainting
__ Fatigue/Malaise
__ Fever
__ Sleeping difficulties / Insomnia
__ Swollen glands
__ Weight gain, unplanned
__ Weight loss, unplanned
__ Other:_____

HEENT
Head
__ Headache
__ Neck lumps/swelling
__ Other:_____
Eyes
__ Blurred vision
__ Double vision
__ Eye changes
__ Other:_____
Date of last eye exam:
_____
Ears
__ Earache
__ Hearing loss / Difficulty
__ Other:_____

Nose
__ Hayfever
__ Sinusitus
__ Other:_____
Throat & Mouth
__ Hoarseness
__ Mouth sores
__ Teeth or gum problems
__ Other:_____
Date of last dental exam:
_____

RESPIRATORY
__ Chronic lung problems
__ Coughing blood
__ Frequent cough
__ Shortness of breath
__ Sleep apnea
__ Wheezing
__ Other:_____
Date of last CXR: _____

CARDIOVASCULAR
__ Artificial heart valves
__ Chest pains
__ History of blood transfer
__ Irregular / rapid heartbeat
__ Poor circulation
__ Swelling of ankles or feet
__ Varicose veins
__ Other:_____
Date of last EKG: _____

GASTROINTESTINAL
__ Bloating
__ Bowel changes
__ Colitis
__ Constipation
__ Diarrhea
__ Difficulty swallowing
__ Excess belching
__ Gas
__ Heartburn
__ Hemorrhoids
__ Hiatal Hernia
__ Indigestion
__ Nausea
__ Nervousness
__ Pancreatitis
__ Rectal bleeding
__ Stomach pain
__ Stools black or tarry
__ vomiting
__ Vomiting blood
__ Other:_____
Date of last Colon cancer screening: _____

GENITOURINARY
__ Blood in urine
__ Difficulty urination
__ Frequent urination
__ Kidney/bladder problems
__ Lack of bladder control
__ Other:_____

HEMATOLOGIC & ALLERGIES LYMPHATIC
__ Allergic disorders
__ Bleeding disorders
__ Cancer _____
__ Swollen glands
__ Other:_____

MUSCULOSKELETAL
Pain, stiffness, swelling in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders
__ Difficulty with balance
__ Difficulty with walking
Date of last fall: _____
Date of last broken bone:
_____

SKIN
__ Bleed or bruise easily
__ Change in mole
__ Hives
__ Itching
__ Rash
__ Skin changes
__ Other:_____

NEUROLOGIC & PSYCHIATRIC
__ Depression or anxiety
__ Forgetfulness
__ Numbness
__ Weakness
__ Other:_____

MEN Only
__ Breast lump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Prostate problems
__ Sore/warts on penis
Date of last PSA: _____

WOMEN Only
__ Abnormal menstrual periods
__ Abnormal Pap smear
__ Bleeding between periods
__ Breast Lumps
__ Extreme menstrual pain
__ Hot flashes
__ Painful intercourse
__ Vaginal discharge or itching
__ Other:
Date of last period: _____
Date of last Pap smear: _____
Date of last mammogram: _____
Are you pregnant? yes / no
Birth control? yes / no

CONDITIONS: Check conditions you have or have had in the past

__ ADD / ADHD
__ AIDS
__ Anemia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding disorder
__ Breast lump
__ Bronchitis
__ Cancer
__ Chicken pox
__ Developmental disability
__ Diabetes
__ Eating Disorders
__ Emphysema
__ Epilepsy / Seizures
__ Glaucoma
__ Colon cancer
__ Crohn's
__ Goiter / GERD
__ Gonorrhea
__ Gout
__ Heart attack
__ Heart disease
__ Heart problems
__ Hepatitis
__ Hernia
__ Herpes
__ High blood pressure
__ High cholesterol
__ HIV positive
__ Kidney disease
__ Liver disease
__ Measles / Mumps / Rubella
__ Migraine headaches
__ Miscarriage
__ Mononucleosis
__ Multiple sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate problems
__ Psychiatric care
__ Rheumatic fever
__ Stomach ulcers
__ Stroke
__ Suicide attempt
__ Thyroid problems
__ Tonsillitis
__ Tuberculosis
__ Vaginal discharge
__ Vaginal disease

Place Patient Sticker here or handwrite

Name: _____

DOB: _____

List doctors who currently treat you and the conditions treated:

_____

_____

_____

Patient and Provider need to Date/Time/Initial

Initial review by Provider: _____ / _____ / _____
Date / Time / Initial

Patient

_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial

Provider

_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial

People assisting with paperwork:

_____ Interpreter's Name
_____ Interpreter's Signature and/or ID #
_____ Date / Time

_____ Office Staff Name
_____ Office Staff Signature
_____ Date / Time

Saint Alphonsus Medical Group

ANNUAL HEALTH HISTORY PAGE 2

Medications and dosages:	**Allergies:**	
1.		
2.		
3.		
4.	**Hospitalizations:**	
5.	1.	2.
6.	3.	4.
7.	5.	6.
8.	**Surgeries:**	
Injuries:		

Immunization - When did you last have? (mm/yyyy)

Immunizations: Tetanus ____ Pneumonia _____ Flu _____ TB _____ Hepatitis B _____ Other _____

Family History (Circle check mark if cause of death.)

	Alcoholism	Asthma	Cancer	Depression	Diabetes	Emphysema	Glaucoma	Heart Attack or Angina	Heart Failure (Weak Heart)	High Blood Pressure	High Cholesterol	Migraine Headaches	Osteoporosis	Stroke	Thyroid Disease	Trouble with blood clotting	Age at Death
Father																	
Mother																	
Brothers																	
Sisters																	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Spouse's Name:** _____
Living arrangements ☐ Alone ☐ Family/Significant Other ☐ Assisted Living ☐ Daily help needed for self care
Name of care giver _____ **Children:** How many? _____ Ages: _____

Occupation: _____ ☐ FT ☐ PT ☐ Self ☐ Retired from:_____
Level of Education: ☐ HS / GED ☐ Tech / A.A ☐ B.S. / B.A. or higher

Diet: ☐ Unrestricted ☐ Low fat ☐ Low carb / diabetic **Caffeine**:☐ No ☐ Yes Type/Amt: _____

Sleep: # of hours per night _____ **Problems:** Falling / Staying asleep? ☐ No ☐ Yes
Exercise: ☐ No ☐ Yes Type: _____ ☐ Once a week ☐ 2-3x/wk ☐ Daily

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory ☐ Dressing
☐ Bathing ☐ Household Duties

Fall Risk: Do you have concerns about falling? ☐ No ☐ Yes Do you use any balance/mobility devices? _____
Learning Needs: Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials? ☐ No ☐ Yes Please explain: _____

Abuse / Neglect: Are you experiencing neglect and/or conflict in your family and/or relationships? ☐ No ☐ Past ☐ Current

Tobacco: ☐ Never ☐ Past ☐ Current
Started: _____ Quit: _____
Packs per day? _____ ☐Smoke ☐Chew

Alcohol: ☐ Never ☐ Past ☐ Current
_____ # of drinks per ☐ Day ☐ Week ☐ Month

Street Drugs: ☐ Never ☐ Past ☐ Current
What? _____
Started: _____ Quit: _____

Place patient sticker here or handwrite

Name: _____

DOB: _____

Saint Alphonsus Medical Group

PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my Spouse/Significant Other about my medical care and test results.
Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to talk with my children or other family members involved with my medical care.
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ Other, please describe: _____

Emergency Contact:

Last Name _____ First Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

Patient Contact:

Patient Email _____
Phone (Home) _____ Phone (Cell) _____
Phone (Work) _____ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

_____ _____ _____
Patient Signature Date Time

People assisting with paperwork:

_____ _____ _____
Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____
Office Staff's name Office Staff Signature Date and Time

Place patient sticker here or handwrite
Name _____
DOB: _____

Insurance/HIPAA E3
Rev 05-02-2011
Form 0003

HAVE PATIENT/GUARDIAN DATE AND INITIAL:

Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials

Saint Alphonsus Medical Group

Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

- We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

- You will receive at least two statements after to your visit at our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

- The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

- I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Saint Alphonsus Medical Group, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

Saint Alphonsus Medical Group

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name _____ **Date of Birth** _____

(Please print)

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

From: _____

Physician/Institution that presently has data

_____

Street Address

_____

City State Zip Phone Fax

To: _____

Physician/Institution requesting data

_____

Street Address

_____

City State Zip Phone Fax

Release the following Protected Health Information:

____ All Records _____ Chart Notes _____ X-Rays _____ Labs _____ Substance Abuse Info _____Mental Health _____ HIV _____ Other (please specify): _____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information) Transfer of care_____

The Protected Health Information is being used or disclosed for the following purpose(s): [If the patient is requesting the release, this may state "at patient's request"]

_____

(List specific purposes the Protected Health Information will be utilized)

_____ Please FAX requested information to the fax number listed above.

(Maximum of 10 pages may be faxed, if request is more, records will be sent to the address indicated above.)

This authorization is in full force and effect until _____ (Date) or until _____ (List specific event)

If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

I understand that I have the right to revoke this authorization in writing by sending notification to:

CLINIC NAME:

ATTN: Privacy Officer

ADDRESS:

I understand that when I revoke this authorization, it is not effective to the extent that the Clinic has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. The Clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party (such as fitness for work exam). I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization. If you have any questions concerning this form, please phone: (-)

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out and initialed. YES_____ NO_____ (initials)

_____ _____

Patient Signature Date and Time

_____ _____ _____

Legal Representative Name/Relationship to patient Legal Representative Signature Date and Time

People assisting with paperwork:

_____ _____ _____

Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____

Office Staff name Office Staff Signature Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____