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: _____

Saint Alphonsus Medical Group

ANNUAL HEALTH HISTORY

Place patient sticker or handwrite

Name: _____

DOB: _____

Today's Date: _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Preferred Pharmacy Name: _____ **Pharmacy Location (Cross Streets):** _____

Do you use Tobacco? ☐ Yes, Currently ☐ No, never ☐ No, I am a former tobacco user
Type of Tobacco Used: ☐ Cigarettes ☐ Chewing ☐ Other _____ How much per day: _____ Years used: _____
Have you ever tried to quit? ☐ Yes ☐ No Year Quit: _____
Are you exposed to passive smoke? ☐ Yes ☐ No

Fall Risk: Have you fallen in the last year? ☐ Yes ☐ No Number of Falls/past year? _____
Do you have problems with walking or balance? ☐ Yes ☐ No

Health Maintenance: Date of last colonoscopy: _____ Date of last Eye Exam: _____ Date of last EKG: _____
Date of last Dental Exam: _____ **Women Only**: Last menstrual period? _____ Date of last pap: _____
Date of last Mammogram: _____ Are you currently pregnant? ☐ Yes ☐ No

Past Medical History: Please mark all that apply.

☐ Allergies	☐ Blood clots	☐ Gallbladder disease	☐ MI (heart attack)
☐ Anemia	☐ Cancer Type:_____	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ CVA (stroke)	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ COPD	☐ High Cholesterol	☐ Peptic Ulcer disease
☐ Arthritis	☐ Coronary Art. disease	☐ High blood pressure	☐ Renal disease
☐ Asthma	☐ Crohn's Disease	☐ Irritable bowel syndrome	☐ Seizure disorder
☐ Atrial Fibrillation	☐ Depression	☐ Liver Disease	☐ Thyroid disease
☐ Benign prostatic hypertrophy	☐ Diabetes	☐ Migraine headaches	☐ Other _____

Past Surgical History:	**Year:**		**Year:**
☐ Angioplasty	_____	☐ Small Bowel Resection	_____
☐ Angio w/stent	_____	☐ Thyroidectomy	_____
☐ Appendectomy	_____	☐ Tonsillectomy	_____
☐ Arthroscopy knee	_____	**FEMALES ONLY:**	
☐ Back surgery	_____	☐ Breast augmentation	_____
☐ CABG	_____	☐ Tubal Ligation	_____
☐ Carpal Tunnel	_____	☐ Breast Biopsy	_____
☐ Cataract extraction	_____	☐ C-Section	_____
☐ Cholecystectomy (gall bladder)	_____	☐ D and C	_____
☐ Colectomy	_____	☐ Hysterectomy	_____
☐ Colostomy	_____	☐ Mastectomy	_____
☐ Gastric Bypass	_____	☐ Myomectomy	_____
☐ Hernia Repair	_____	☐ Breast reduction	_____
☐ Hip replacement	_____	☐ TAH/BSO	_____
☐ Knee replacement	_____	☐ Vaginal Hysterectomy	_____
☐ LASIK	_____	**MALES ONLY:**	
☐ Liver biopsy	_____	☐ Prostate biopsy	_____
☐ ORIF	_____	☐ TURP	_____
☐ Pacemaker	_____	☐ Vasectomy	_____

Family History of (mark all that apply and indicate for Mother, Father, Siblings):

☐ ADD/ADHD _____	☐ CVA (stroke) _____	☐ Learning Disability _____	☐ Other _____
☐ Alcoholism _____	☐ Depression _____	☐ Mental Illness _____	
☐ Allergies _____	☐ Developmental delay _____	☐ Migraines _____	**Age/cause of death of:**
☐ Alzheimer's disease _____	☐ Diabetes _____	☐ Obesity _____	Mother: ☐ n/a _____
☐ Asthma _____	☐ Eczema _____	☐ Osteoarthritis _____	Father: ☐ n/a _____
☐ Blood disease _____	☐ Hearing Deficiency _____	☐ Osteoporosis _____	Siblings:☐ n/a _____
☐ CAD _____	☐ High Cholesterol _____	☐ Peripheral Vascular disease	
☐ Cancer: Type _____	☐ High blood pressure _____	☐ Renal disease _____	
	☐ Irritable bowel syndrome ___	☐ Seizure disorder _____	

Social History:

Marital Status:	**Living Arrangements:**	**Activities of Daily Living:**	**Learning Needs:**
☐ Married ☐ Single	☐ Alone ☐ Family/Sig.Other	Any difficulty with?	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?
☐ Divorced ☐ Widowed	☐ Other ☐Asst. Living	☐ Speech/Communication	
Alcohol Consumption:	☐ Daily help needed for self-care	☐ Memory	☐ Yes ☐ No
☐ No ☐ Yes ☐ Formerly	Name of Caregiver:_____	☐ Bathing	Please explain: _____
Type: _____ Frequency: _____		☐ Household Duties	
Amount: _____	**Abuse / Neglect: Adults only**	# of Children: _____	
Caffeine:	Are you experiencing neglect and/or conflict in your family and/or relationships?☐Yes ☐No	**Street Drug Use?** ☐ Yes ☐ No	
☐ No ☐ Yes Type: _____	Explain: _____	Type: _____	
Caffeine per day: _____		Started: _____	
Reviewed by: _____		Quit: _____	
Date: _____			

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: _____