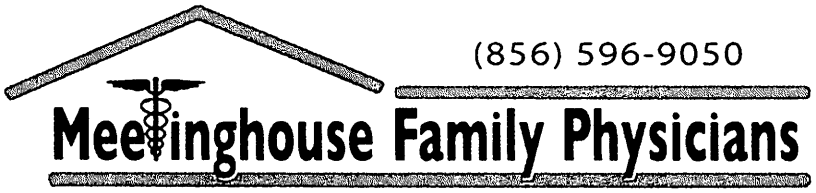
Patient Registration Form



Date: _____ Patient Number (*Office Use*): _____

Patient Information:

Last Name: _____ Date of Birth: _____

First Name: _____ MI: _____

Mailing Address: _____

City_____ State: _____ ZIP: _____

Billing Address: ☐ Same as Mailing _____

City_____ State: _____ ZIP: _____

Cell: _____Home: _____Work: _____

Social Security Number: _____ Employer/School: _____

Employment Status: ☐ Full Time ☐ Part-time ☐ Unemployed ☐ Self-Employed ☐ Retired ☐ Student

Billing Information:

Responsible Party Information (*if other than self*):

Name: _____ Phone: _____

Address: _____

Relationship to Patient: _____ Is this person a patient here? ☐Yes ☐No

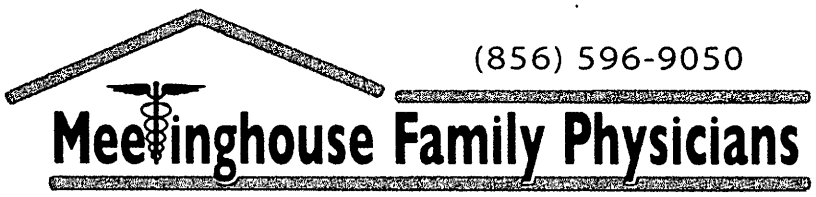
Insurance Information:

Insurance Company: _____ Member ID: _____

(*If other than self*) Patient Relationship to Subscriber: _____

Name of Subscriber/Insured: _____

Subscriber Date of Birth: _____ Subscriber Phone Number: _____



Secondary/Additional Insurance (*if applicable*):

Patient Information:

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male

☐ Male-to-Female (MTF)/ Transgender Female ☐ Genderqueer

☐ Additional Gender, please specify: _____ ☐ Choose Not to Disclose

Sexual Orientation: ☐ Lesbian, Gay, or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Unsure

☐ Additional Orientation, please specify: _____ ☐ Choose Not to Disclose

Marital Status: ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Married ☐ Partner

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Specify

Hispanic or Latino? ☐ Yes ☐ No ☐ Decline to Specify

Emergency Contacts:

1) Name: _____ Phone: _____ Relationship: _____
2) Name: _____ Phone: _____ Relationship: _____

I permit my provider to release medical billing data to my insurance carrier. I understand that I am financially responsible for any and all balance not covered by my insurance carrier. Meetinghouse Family Physicians reserves the right to charge a fee for any appointment not cancelled at least 24 hours prior. A copy of this signature is as valid as the original.

Patient Signature: _____ **Date:** _____

HIPAA (Health Insurance Portability and Accountability Act)

Authorization for Use or Disclose Protected Health Information in Compliance with The Privacy Rule
(45 CFR Part 160 and Subparts A and E of Part 164)

Information may be used by the person(s) listed below to receive information regarding medical treatments, consultations, billing, claims, payments, and/or other purposes as I direct. I authorize **Meetinghouse Family Physicians** to use and disclose protected health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization for release of personal health information covering the period of healthcare: (*select one*)

- ☐ From _____/_____/_____ to _____/_____/_____
- ☐ All past, present, and future dates.

I hereby authorize the release of personal health information as follows: (*select one*)

- ☐ My complete health record (mental health, communicable disease, HIV/AIDS, and treatment of alcohol and/or drug abuse).
- ☐ Limited access to (*select all that apply*):
  - ☐ Mental health
  - ☐ Communicable disease (HIV/AIDS)
  - ☐ Drug and/or alcohol abuse and/or treatment
  - ☐ Medications (controlled and non-controlled)

This authorization will be valid for 1 year or 9 months after my death. I understand that I have the right to revoke this authorization in writing at any time. I understand that I am unable to retroactively revoke this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed to the person(s) listed above will no longer be protected by federal or state law.

Patient Signature: _____

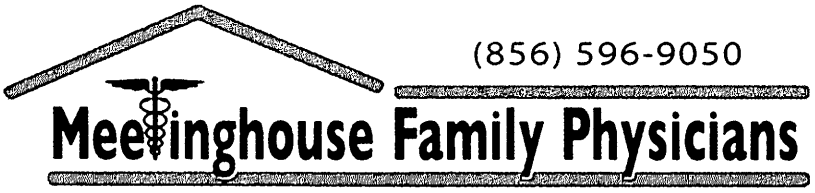
Patient Printed Name: _____

Date of Birth: _____ Today's Date: _____

Patient Legal Representative Signature: _____

Patient Legal Representative Printed Name: _____

Today's Date: _____



Comprehensive Health Assessment Questionnaire

Our goal is to be your "Coordinator of Care" and provide comprehensive care, physically, mentally, and emotionally. This is an extensive questionnaire used to determine your treatment plan. Please take the time to complete it to the best of your ability.

Medication *(please include name, dosage, and schedule. Include over the counter medications, supplements, and vitamins)*

Allergies *(please include medication, food, environmental, animal, plants)*

Personal and Family History: For each bodily system, please indicate whether you have had any of the symptoms or conditions.

Symptom / Condition	Self	Mother	Father	Comments
Constitutional:				
Fever				
Night Sweats				
Weight Gain- how much weight & over what length of time?				
Weight loss- how much weight & over what length of time?				
Frequent or Chronic Sinus problem				
Visual Changes				
Other:				
Respiratory System				
Emphysema / Chronic Bronchitis				
Pneumonia				
Snoring /Sleep Apnea				
Cough /Wheeze /Shortness of Breath				
Other				
Cardiac System / Risk Factors				
Chest Pain /Angina				
Heart Attack				
Stroke				
Coronary Artery Disease				
High Cholesterol				
Edema (swelling of the legs)				
Arrhythmia				
Hypertension (high Blood Pressure)				
Peripheral Vascular Disease				
Chronic or End Stage Kidney Disease				
Diabetes				
Other				
Gastrointestinal System				
Abdominal Pain				
Change in Bowel Habits				
Nausea / Vomiting				
Loss of Appetite				
Irritable bowel Syndrome				
Liver Disease- Hepatitis, Cirrhosis, Fatty Liver				
Hemorrhoids				
Diverticulosis or Diverticulitis				
Colon Polyps				
Gallbladder Disease				
Ulcers- please indicate location				
Other				
Reproductive System	***Self***	***Mother***	***Father***	***Comments***
Fibroids				

Reproductive System cont.	Self	Mother	Father	Comments
Vaginal Discharge or Dryness				
Breast Pain /Mass/ Cyst				
Other				
Integumentary (Skin) System				
Skin Changes – Moles/ lesions				
Hair Changes- Thinning/Loss/growth				
Eczema				
Psoriasis				
Dry Skin				
Rash				
Other				
Psychiatric System				
Sleep Problems-Falling Asleep, Stay Asleep				
Anxiety/Depression				
Bipolar/Schizophrenia				
Other				
Neurological System				
Frequent Falls				
Headache Migraine				
Memory Loss- Alzheimer's, Dementia, etc.				
Seizures/Epilepsy				
Other				
Metabolic / Endocrine System				
Thyroid Disorder- Hyper or Hypo				
Diabetes- What type				
Other				
Musculoskeletal System				
Joint Pain				
Muscle Weakness				
Swelling				
Arthritis				
Gout				
Chronic Pain				
Fractures- please indicate where				
Other				
Blood or Bleeding Disorder				
Anemia				
Blood clot				
Blood Transfusion				
Other				
General				
Cancer- type?				
Alcohol/ Drug Abuse				
Tobacco User				
Allergies- Seasonal or environmental				
Other				

Immunizations: Please indicate the year in which you received the vaccine.

Vaccine	Received	Date
Tetanus (Td)		
Tetanus with Pertussis (tdap)		
HPV		
Influenza		
Pneumovax		
Zostavax (Shingles)		

Screen Testing: Please indicate the year in which you completed each test.

Test	*Received*	*Date*
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		

Family History

	Father	Mother	Grandmother	Grandfather	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased (List age)										
Diabetes										
Chronic Lung Disease										
Hypertension										
Heart Disease										
Stroke										
Kidney Disease										
Obesity										
Genetic Disorder										
Alcoholism										
Liver Disease										
Depression or Bipolar Disorder										
Colon or Rectal Cancer										
Breast Cancer										
Other Cancer										
Drug Abuse										
Other										

General Information:

Within the past twelve months have you been in the hospital? Yes No
If yes, please explain: _____

Within the past twelve months, have you seen any other physician? Yes No
If yes, please explain: _____

Do you have a "Living Will"? Yes No

Do you have a "Power of Attorney"? Yes No

Does *Meetinghouse Family Physicians'* have copies of the above to documents? Yes No

Alcohol/ Caffeine Use:

Do you drink caffeine? Yes No

Do you drink alcohol? Yes No

Number of drinks per week of alcohol? _____

Type of Alcohol? Beer Wine Liquor

Number of caffeine drinks per week? _____

Type of caffeine: Coffee Tea Soda Energy Drink

Tobacco/ Drug Use

Smoke Cigarettes: Never Former Yes

Quit Date: _____ How many years did you smoke? _____

How many cigarettes did you smoke? _____

Current Smoker: Cigarettes per day _____ Number of years _____

Do you currently use Electronic Cigarettes or Vape? _____

Have you ever chewed tobacco? Yes No

Have you had exposure to second hand smoke? Yes No

Do you use street drugs? Yes No

Type: Marijuana Cocaine Heroin Amphetamines

Other: _____

List any handicaps: _____

Do you exercise regularly? Yes, No **Amount /Type** _____

Highest level of Education _____

Preferred Language: _____

Occupation: _____

Are there any barriers keeping you from achieving your medical goals? (Transportation, complexity of care, cost of medication, amount of medication prescribed or any other barriers) _____

_____

_____

Thank you for taking your time to fill out this form.