PATIENT REGISTRATION

Please Print Today's Date _____

Patient's First Name _____ MI ____ Last Name _____

SEX: □ M □ F □ Unknown □ Decline

DATE OF BIRTH ____/____/____ AGE _____ PATIENT'S SS# _____-_____-_____

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____EMAIL_____

PHYSICAL ADDRESS IF DIFFERENT THAN MAILING

_____

CITY _____ STATE _____ ZIP _____

IF YOU ARE A PART TIME RESIDENT PLEASE PROVIDE YOUR PERMENATE MAILING ADDRESS

_____

CITY _____ STATE _____ ZIP _____

PREFERRED CONTACT METHOD FOR APPOINTMENT REMINDERS

□Home phone □Cell phone □Work phone

HOME PH _____ CELL PH _____ WORK PH _____

Emergency Contact Name _____ Ph. (___) _____

Relationship _____

****

RACE

□ American Indian or Alaska Native
□ Asian
□ White
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ Decline

ETHNICITY - □ Hispanic or Latino □ Non-Hispanic or Latino □ Decline

PREFERRED LANGUAGE _____ □ Decline

****

If Patient is under 18 years please complete for Parent or Guardian:

Name - _____

Address (if different) - _____

City: _____ State: _____ Zip: _____

Relationship to minor child: _____

Home Ph (_____) _____ Work Ph (_____) _____

INSURANCE INFORMATION

Today's Date: _____

Primary of Insurance Plan: _____

ID #: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Address: _____

_____, _____ _____

City State Zip

Policy Holders Date of Birth: _____

Policy Holders Home Phone: _____

Policy Holders Social Security Number: _____

Secondary Insurance Plan: _____

ID #: _____ Effective Date: _____

Policy Holder Name: _____

Policy Holder Address: _____

_____, _____ _____

City State Zip

Policy Holders Date of Birth: _____

Policy Holders Home Phone: _____

Policy Holders Social Security Number: _____

As the patient or parent/guardian I understand that it is my responsibility to provide any updates and changes in my insurance coverage to the receptionist **PRIOR** to receiving services from Chiefland Medical Center, LLC. I also understand employees of Chiefland Medical Center cannot guarantee any coverage of my benefits for services provided. I understand that any services provided by Cheifland Medical Center, LLC that are not a covered benefit under my plan are my responsibility and I will be bill for these uncovered services. I understand that any laboratory services drawn at Chiefland Medical Center, LLC are sent to outside laboratory's (ex: LabCorp/Quest) and those services are billed separately by those companies. It is my responsibility to know my insurance companies preferred lab and insure that I request these services be used.

Patient Signature: _____ Date: _____

PATIENT HISTORY

Patient Name: _____ DOB: _____

PATIENT HISTORY:

	None	Past	Present	Fam Hist
Fever	☐	☐	☐	☐
Chills	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Visual Problems	☐	☐	☐	☐
Hearing Problems	☐	☐	☐	☐
Numbness	☐	☐	☐	☐
Cough	☐	☐	☐	☐
Shortness of Breath	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Sinus Infection	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐
Blood Clot/DVT	☐	☐	☐	☐
Bruising	☐	☐	☐	☐

	None	Past	Present	Fam Hist
Palpitations/Irregular Heart Beat	☐	☐	☐	☐
Chest Pain	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐
Nausea / Vomiting	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Liver Disorder	☐	☐	☐	☐
Intestinal Disorder	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐
Gastroesophageal Reflux	☐	☐	☐	☐
Internal Bleeding	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Pain / Difficulty Urinating	☐	☐	☐	☐
Kidney Problem	☐	☐	☐	☐
Prostate Enlargement	☐	☐	☐	☐
Rashes	☐	☐	☐	☐
Burns	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Other Arthritis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐
Pain In Joints	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐
Excessive Thirst	☐	☐	☐	☐

IMMUNIZATIONS: Indicate year, if known

Tetanus (td) _____
Tetanus with Pertussis (Tdap) _____
Varicella or illness (Chicken Pox) _____
Pneumovax (pneumonia) _____
Influenza _____
Hepatitis A _____

Hepatitis B _____
MMR _____
Meningitis _____
Zostavax (shingles) _____
HPV _____

Patient Name: _____ DOB: _____

HEALTH MAINTENANCE SCREENINGS: when and where

Colonoscopy-_____ Bone Density Test-_____ PSA-_____
Mammogram-_____ Pap Smear-_____ Cholesterol Screening-_____

ALLERGIES and reaction to:

_____
_____
_____

WOMENS HEATH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: _____

Age Menstruation began: _____ Age Menopause began (if applicable) _____

HEALTH ISSUES:
Tobacco Use: Yes Never
Current Smoker: Packs day - _____ # of years _____
Former Smoker: Quit Date - _____
Packs day - _____ # of years _____
Other Tobacco: Chew Snuff
Current - _____ Quit Date - _____
Are you ready to Quit? Yes No

ALCOHOL USE:
Do you drink alcohol? Yes No
Beer Wine Liquor
# of drinks a week? _____

SEXUAL ACTIVITY:
Are you sexually involved? Yes No Never
Birth control method or STD prevention: _____
_____

EXERCISE:
Do you exercise regularly? Yes No
If yes, What type of exercise? _____
_____

PREFERRED PHAMACY: _____

No Current Medications: Yes No

Medication and Supplements	Dosage	Reason for taking:	Prescribed by:

CONSENTS

Patient Name: _____ DOB: _____

COMMUNICATION WITH FAMILY OR OTHERS INVOLVED IN YOUR CARE

Please list anyone who may be involved in coordinating your care. You may update this in writing at any time.

Name	Relationship	Phone Number

_____ ____/____/____

Patient Signature Date

****

PRESCRIPTION HISTORY CONSENT

I agree that Chiefland Medical Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefits payors for treatment purposes.

_____ ____/____/____

Patient Signature Date

****

CONSENT TO EXAMINATION / TREATMENT
INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION AND INFORMATION ACKNOWLEDGEMENT

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS. I HEREBY AUTHORIZE CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY CONSENT TO THE USE OF A PATIENT PORTAL. I HEREBY ASSIGN TO CHIEFLAND MEDICAL CENTER AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I ACKNOWLEDGE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE _____ DATE ___/___/___

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR) _____

AUTHORIZATION FOR MEDICARE BILLING PURPOSES
LIFETIME FILE (MEDICARE PATIENTS ONLY)

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

SIGNATURE _____ DATE ___/___/___

ACKNOWLEDGEMENT NOTICE & SHARE RECORD RELEASE

I understand that my health care provider creates and uses a record of my health history and related financial information that may be used for:
Continuing care and treatment:
*A way of communicating with other health care professionals and pharmacies who are involved in my care
*Deriving information used in billing for my care
*A means of responding to insurers requests for information about my care
*Review in quality assessment projects designed to help the clinic improve its ability to provide good health care.

My signature below acknowledges my awareness of the above potential uses of my records and also signifies that I was given a "Notice of Privacy" that this notice provides a more complete description of the ways my medical record might be used or disclosed when I registered as a patient at Chiefland Medical Center, LLC (CMC). I understand that the clinic's policies about using information might change from time to time and that I can obtain another copy of the notice at the front desk at any time I want one.

I know that I can request restrictions on the way my health care information is used, but I also understand that CMC is not required to abide by my restrictions. I also understand that I can revoke this consent at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

_____ _____
SIGNATURE DATE

_____
PRINT NAME

****

PATIENT SELF DETERMINATION ACT QUESTIONAIRE
DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs, but by having an **advance directive**, you can have the peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life-Prolonging Procedures (Living Will):
( ) I have made a Living Will
( ) I do NOT have a Living Will
Health Care Surrogate:
( ) I have designated a Health Care Surrogate
( ) I have NOT designated a Health Care Surrogate
Durable Power of Attorney
( ) I have appointed a Durable Power of Attorney for Health Care decisions
( ) I have not appointed a Durable Power of Attorney for Health Care decisions

_____ _____
SIGNATURE DATE

_____
PRINT NAME