

# Aspen Health Care Clinic

## REGISTRATION FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	<b>Date Of Birth:</b>
<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
<b>Address:</b>		<b>City, State, Zip:</b>	
<b>Home Phone:</b>		<b>Cell Phone:</b>	
<b>Email:</b>		<b>SSN:</b>	
<b>Race:</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other		<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
<b>Occupation:</b>		<b>Employer:</b>	

### INSURANCE INFORMATION

<b>Primary Insurance Company:</b>	<b>ID/Policy#:</b>	<b>Group#:</b>
<b>Insurance Company Address:</b>	<b>City/State:</b>	<b>Zip:</b>
<b>Insurance Company Phone:</b>		
<b>Secondary Insurance Company:</b>	<b>ID/Policy#:</b>	<b>Group#:</b>
<b>Insurance Company Address:</b>	<b>City/State:</b>	<b>Zip:</b>
<b>Insurance Company Phone:</b>		
<b>Subscriber Name:</b>	<b>Subscriber DOB:</b>	<b>Subscriber SSN:</b>
<b>Patient's relationship to subscriber:</b>		

### EMERGENCY CONTACT

<b>First Name</b>	<b>Last Name</b>	<b>MI</b>	<b>DOB</b>
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Check Primary phone</b>	<b>Home:</b> <input type="checkbox"/>	<b>Work:</b> <input type="checkbox"/>	<b>Cell phone:</b> <input type="checkbox"/>
<b>Relationship to patient:</b>			
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HILLCROFT PHYSICIANS, P.A. or insurance company to release any information required to process my claims.</p>			

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Please Print)

Relationship to Patient

Name:

DOB:

**Medical History**

**Reason for today's visit:**

**Current Problems:** *(Please circle each of the following you are currently experiencing or have experienced recently)*

<b>General:</b>	Fever, chills, weight loss, weight gain, fatigue, weakness
<b>EENT:</b>	Eye problems, sore throat, hearing difficulties, sinus problems, runny/stuffy nose
<b>Respiratory</b>	Cough, shortness of breath, wheezing
<b>Cardiac:</b>	Chest pain, racing heart, heart fluttering
<b>Gastrointestinal:</b>	Nausea, vomiting, diarrhea, constipation, rectal bleeding, abdominal pain
<b>Urinary:</b>	Painful urination, frequent urination blood in urine
<b>Genitals:</b>	Discharge, abnormal odor, painful sex
<b>Skin:</b>	Rash, discoloration, wounds, hair loss, change in mole
<b>Neurological:</b>	Loss of consciousness, double vision, dizziness, lightheadedness, headaches
<b>Mental health:</b>	Anxiety, depression, difficulty concentrating, insomnia
<b>Musculoskeletal:</b>	Joint pain, joint swelling, stiffness, muscle aches, back pain

**Allergies to medications** Yes  / No

Name the Drug	Reaction You Had

**Medications** *List ALL current medicines (including any painkiller and psychiatric medicine)*

Medication	Dosage	Frequency
1.		
2.		
3.		

**SOCIAL HISTORY**

Are you married? \_\_\_\_\_ How many people live in your home including you? \_\_\_\_\_  Yes  No

Do you smoke now? \_\_\_\_\_ In the past? \_\_\_\_\_ How many each day? \_\_\_\_\_ How many years have or did you smoke? \_\_\_\_\_

Do you ever drink any alcoholic beverages? If yes, how much and how often? \_\_\_\_\_  Yes  No

Do you use any other drugs? If yes, which ones? \_\_\_\_\_  Yes  No

**FEMALES ONLY**

How many times have you been pregnant? \_\_\_\_\_

When was your last well woman exam? \_\_\_\_\_

When was your last mammogram? (Age 35 & older) \_\_\_\_\_

**MALES ONLY**

Do you have any sensation of not emptying your bladder?

Do you have to push or strain to begin urination? \_\_\_\_\_

Do you have a weak urinary stream? \_\_\_\_\_

How many times do you get up at night to urinate? \_\_\_\_\_

**MEDICAL HISTORY**

*Previous/Current medical problems (Check if appropriate) (PMHX)*

<input type="checkbox"/> Allergies	<input type="checkbox"/> Back pain (Chronic)	<input type="checkbox"/> Cirrhosis of liver	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Seizure	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bronchitis (Chronic)	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Stroke	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Other _____

**SURGICAL HISTORY**

	Year		Year		Year
Angioplasty	<input type="checkbox"/>	Cholecystectomy	<input type="checkbox"/>	Knee Replacement	<input type="checkbox"/>
Appendectomy	<input type="checkbox"/>	Colectomy	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Arthroscopy Knee	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>
Back surgery	<input type="checkbox"/>	Gastric Bypass	<input type="checkbox"/>	Prostate Biopsy	<input type="checkbox"/>
Carpal Tunnel Release	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>
Cataract Extraction	<input type="checkbox"/>	Hip Replacement	<input type="checkbox"/>	Other	<input type="checkbox"/>

**Female ONLY**

Augmentaion Mammoplasty	<input type="checkbox"/>	Cesarean Section	<input type="checkbox"/>	Other	<input type="checkbox"/>
Bilateral Tubal Ligation	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>	Other	<input type="checkbox"/>
Breast Biopsy	<input type="checkbox"/>	Mastectomy	<input type="checkbox"/>	Other	<input type="checkbox"/>

**FAMILY HEALTH HISTORY**

<b>Diagnosis</b>	Mother (Deceased/Alive)	Father Deceased/Alive	Brother	Sister	Other: _____	Other: _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PROVIDER'S NOTES:**

## Important Decisions about Your Healthcare Choices

An Advance Care Plan may shape how you experience a period of disability or the very final stage of your life. You and your family may have to face some critical treatment choices. We **respect** your right to make individual decisions that are based on the medical information you have been given and your personal beliefs and values. You can help others respect your wishes in these circumstances if you take steps beforehand to put in place a plan that represents your personal beliefs and values.

How do you ensure that your family knows what your beliefs and values are around your medical care? One way to do this is by developing your own Advance Care Plan that represents your "values history" and a clear understanding of your health-related decisions and preferences.

### **Advance Care Planning**

A process of decision-making done in advance of an illness or injury to plan with your family, Physicians, or spiritual leader what choices you would make if you became unable to communicate those choices for yourself. An Advance Care Plan is another term for Advance Directive or Living Will. While the content may be the same or similar, the main difference is an Advance Care Plan puts more emphasis on talking with family, physicians and spiritual advisors about your wishes. The Advance Care Plan or Advance Directive will involve important areas of healthcare such as: Cardiopulmonary Resuscitation (CPR), Do Not Resuscitate Order (DNR), Durable Do Not Resuscitate Order (DDNR) and Living Will As well as other important aspects of healthcare management.

Once you have completed your Advance Care Plan, you should make copies of it. Keep the original and send copies to your healthcare agent(s), other family who are likely to come to your bedside at the hospital, **your primary care physician**, and the US Living Will Registry\*. Keep a list of everyone who has a copy of your document **Remember: Any time you update your document, you should send an updated copy to everyone who had a copy of the old one.**

Hillcroft Physicians urges you to have this discussion with your family members and other important persons in your life so you can have an Advance Care Plan and Advance Directive in place.

Please sign below that you have read this information and understand what its message is. Thank you.

I have read and fully understand this agreement.

\_\_\_\_\_

Patient Name

\_\_\_\_\_

Date

\_\_\_\_\_

DOB

# HIPPA Privacy Rule

## Patient Authorization Agreement

### Authorization for Release of Protected Health Information for Treatment, Payment or Health Care (§164.508 (a))

I, \_\_\_\_\_ (name of patient), I understand that as part of my healthcare, this office creates and maintains health records describing my health history, symptoms, examinations and results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication between professionals in the medical field that can contribute to my care;
- A source of information on how to apply my diagnosis and surgical information to my bill;
- A means by which a payer can verify that services billed were actually provided;
- A means for routine health care operations such as quality determination and complete information on the uses and disclosures.

I have been provided (a) a copy of the **Notice of Privacy Practices** that provides a more complete description of the uses and disclosures.

I understand that as part of my care and treatment may be necessary to provide another entity my Medical Confidential information. I have the right to review the notice of this office before signing this authorization. I authorize the disclosure of my confidential medical information as will be later specified for the purposes and to the groups mentioned by me.

## Standard Privacy- Patient Consent

### Consent for Disclosure of Protected Health Information for Treatment, Payment or Health Care (§164.506(a))

I understand that

- I have the right to review the Notice of information practices of this office before signing this consent;
- That this office reserves the right to change the notice and practices, and that if I request a copy of the notice sent to the address published've given before putting it into practice;
- I have the right to request restrictions as to how my confidential medical information may be used or disclosed for treatment, payment or health care that is not required by law that this office will agree to the restrictions requested;
- I may revoke this consent in writing at any time except to the extent that this office has already taken action, depending on the written consent.

Signature of Patient or Legal Representative Witness: \_\_\_\_\_

Name of Patient or Legal Representative Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# HIPPA PRIVACY RULE

## Receipt of Notice of Privacy Practice Written Acknowledgement Form

### Acknowledgement of Receipt of Notice of Privacy Practice (§164.520 (a))

I, \_\_\_\_\_ (the patient's name), I understand that as part of my healthcare, this office creates and maintains medical document describing my health history, symptoms, examination and results, diagnoses, treatment and any plans for future care or medical treatment. I acknowledge that I have been provided and understand that the **Notice of Privacy Practices** from this office provides a complete description of the use and disclosure of my health information. I understand that:

- I have the right to review the **Notice of Privacy Practices** from this office before signing this form;
- That this office reserves the right to change the **Notice of Privacy Practices** and send a copy of the notice published at the address I have given before putting it into practice, if I requested

Signature of Patient or Legal Representative Witness: \_\_\_\_\_

Name of Patient or Legal Representative Witness: \_\_\_\_\_

Date: \_\_\_\_\_

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### INTERNAL OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but has not been obtained because:

- Individual refused to sign
- Communication difficulties forbade us from obtaining acknowledgment
- An emergency forbade us from obtaining acknowledgment
- Other (please specify)

\_\_\_\_\_  
\_\_\_\_\_

Privacy Officer: \_\_\_\_\_

Date: \_\_\_\_\_

**Patient Agreement  
&  
Authorization for the Release of Medical and Health Plan Documents for the Claims  
Processing & Reimbursement As Required by Federal and State Laws**

**Legal Assignment of Benefits and Designation of Authorized Representative**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

\_\_\_\_\_  
Signature of Insured / Guardian

\_\_\_\_\_  
Date