PETERSON HEALTH

# PATIENT REGISTRATION FORM

## VISIT INFORMATION

Physician or provider you intend to see:

Reason for your visit:

Is this appointment related to a workers compensation injury? ❑ Yes ❑ No
Is this appointment related to a motor vehicle accident? ❑ Yes ❑ No

## PATIENT IDENTIFICATION

| Last Name: | | First Name (Legal): | | First Name Used: |
|---|---|---|---|---|
| Middle Initial: | Previous Name: | Legal Sex: ❑ M ❑ F | Date of Birth: | SSN: |

## CONTACT

| Address: | | Zip Code: | City: | State: |
|---|---|---|---|---|
| Home Phone: | Mobile Phone: | Consent to Call ❑Yes ❑ No<br>Consent to Text ❑Yes ❑ No | Work Phone: | |
| Email: | | ❑ No e-mail address<br>❑ Prefer not to share | Contact Preference:<br>❑ Home ❑ Cell ❑ Work ❑ E-mail | |

## EMERGENCY CONTACT

| Contact Name: | Phone Number: | Relationship: |
|---|---|---|

## DEMOGRAPHICS

Preferred Language: | Secondary Language:

Race: ❑ Asian ❑ Black/African American ❑ American Indian ❑ Hispanic or Latino ❑ Multi-racial ❑ Pacific Islander ❑ White

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown ❑ Other:
(Ethnicity is your ancestral or culture background)

Marital Status:
❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation:

## RESPONSIBLE PARTY INFORMATION (Complete only if different than patient above)

| Last Name: | First Name: | Initial: | Date of Birth: | |
|---|---|---|---|---|
| Address: | | City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: | SSN: | Gender: ❑ M ❑ F |
| Occupation: | | Relationship: | | |

## INSURANCE INFORMATION

Primary Insurance:

| Policy Holder: | Insured's Date of Birth: | Insured's SSN: |
|---|---|---|
| Insured Employer's Name: | Policy #: | Group #: |

Secondary Insurance:

| Policy Holder: | Insured's Date of Birth: | Insured's SSN: |
|---|---|---|
| Insured Employer's Name: | Policy #: | Group #: |

If you are over 65 years old and Medicare is your SECONDARY policy, please list reason:

## CONSENT TO TREAT

I give permission for Peterson Medical Associates (PMA) to render to me (and/or my named dependent above) medical treatment. I also understand I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.

## ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Peterson Medical Associates for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine the benefits payable for related and/or provided services. **I understand that I must pay my share of the costs, including co-pays and deductibles at each visit. Furthermore, if my insurance does not pay or I do not have insurance, I must pay for the cost of these**

_____
Patient Signature for Consent to Treat and Assignment of Benefits

_____
Date Signed

_____
Signature of Patient Representative (if patient unable to sign)

Relationship to Patient:

Reason Patient Unable to Sign:

# PATIENT CONSENT & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

PETERSON HEALTH

I understand that as a part of the provision of healthcare services, Peterson Health creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnosis(es), treatment, and any plan(s) for future care or treatment.

The Notice of Privacy Practices which provides a more complete description of the uses and disclosures of certain health information is posted at all practice locations. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy of facsimile of this consent is as valid as the original
3. I have the right request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my protected health information which have been previously agreed upon.

| | |
|---|---|
| Patient Printed Name | Date of Birth |
| Patient Signature | Signature Date |
| Representative Printed Name (if patient unable to sign) | Relationship to Patient |
| Representative Signature (if patient unable to sign) | Representative Signature Date |
| Reason Patient Unable to Sign | |

# PATIENT HIPAA ACKNOWLEDGEMENT/DISCLOSURE

PETERSON HEALTH

I understand Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected health information ("PHI"). This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the person(s) designated below in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends. Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) Peterson Health, a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR §164.508.

I,_____ , hereby authorize Peterson Health to disclose the following information:
Print Patient Name

*All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.*

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created in HIPAA. This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by Peterson Health.

| How can we communicate your protected health information with you? | | |
|---|---|---|
| Home Phone | | Leave detailed message on voicemail? ❑ Yes ❑ No |
| Cell Phone | | Leave detailed message on voicemail? ❑ Yes ❑ No |
| Work Phone | | Leave detailed message on voicemail? ❑ Yes ❑ No |

| Please list below any family or friends you authorize us to communicate with regarding your health information. (Leave blank if none) | |
|---|---|
| Name: | Relationship: |
| Primary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |
| Secondary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |
| | |
| Name: | Relationship: |
| Primary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |
| Secondary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |
| | |
| Name: | Relationship: |
| Primary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |
| Secondary Phone: | Leave detailed message on voicemail? ❑ Yes ❑ No |

_____ _____
Patient or Representative Printed Name Date of Birth

_____ _____
Patient or Representative Signature Signature Date

# PRACTICE POLICIES AND GUIDELINES AGREEMENT

PETERSON HEALTH

Welcome! We are so glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return it to our office. Thank you for your cooperation.

1. **First Time Visit** – Please arrive 30 minutes before your scheduled appointment time. Failure to arrive 30 minutes prior to your first appointment may result in rescheduling the appointment. The clinical staff will go over your medications and past medical history. Please bring all of your medications in their original containers. Missed appointments for new patients may not be rescheduled. If you have a co-pay or have not yet met your deductible, please be prepared to pay it when you check in at the front desk. If you are a self-pay patient, payment will be due at the time of service.

2. **Follow-Up Visits** – Please arrive 15 minutes before your scheduled appointment time. It is our goal for you to be ready to see your provider on time. Follow-ups are scheduled based on the particular needs of specific disease processes. If you have multiple chronic illnesses, you may be scheduled for multiple follow-up visits.

3. **Late Arrivals** - We all run late sometimes. If you arrive after your scheduled appointment time, we will try our best to work you back into the schedule. Depending on availability, you may be required to reschedule your appointment.

4. **Appointment Cancellation Protocol** – If you need to cancel your appointment, we ask that you do so at least 24 hours in advance. Although unexpected events may necessitate missing an appointment, if you miss appointments without following the cancellation protocol then you may be charged $25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice.

5. **Established patients** who need acute care should call as early in the day as possible so that we can accommodate you. Depending on the availability of your provider, same day appointments may not be an option or you may be asked to see another provider.

6. **Medication Refills** - For medication refills, ask your pharmacy to send us a refill request and please allow 2 business days. All controlled medications (ex. Norco, ADD meds) require 5 business days notice prior to refill. Controlled medications will only be written for a 30-day supply at a time. Additional refills to the original prescription will be at the provider's discretion. Early refills will not be given. Additional follow-up appointments may be required for certain medication refills. You may be requested to contact your pharmacy to ask them to send a refill request to our office as this is the quickest way to receive a refill.

**As a courtesy, please turn off or silence your cell phone during your office visit.**

I have read and understand the above office policies and agree to abide by them.

| | |
|---|---|
| Patient Printed Name | Patient Date of Birth |
| Patient Signature | Signature Date |
| Representative Printed Name (if patient unable to sign) | Relationship to Patient |
| Representative Signature (if patient unable to sign) | Representative Signature Date |

# MEDICATION LIST

PETERSON HEALTH

PATIENT NAME (IN FULL) DATE OF BIRTH: TODAY'S DATE:

| PREFERENCES | |
|---|---|
| Preferred Local Pharmacy: | Preferred Lab: |
| Preferred Mail Order Pharmacy: | Preferred Imaging: |

**MEDICATION ALLERGIES**

❑ None ❑ Yes, specify:

**FOOD OR OTHER ALLERGIES**

❑ None ❑ Yes, specify:

| Medication Name | Dose (i.e., mg or mcg) | Route (i.e oral, injection) | How many times taken per day? |
|---|---|---|---|
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NEW PATIENT HEALTH HISTORY

PETERSON HEALTH

PATIENT NAME (IN FULL) DATE OF BIRTH: TODAY'S DATE:

| IMMUNIZATIONS | | | |
|---|---|---|---|
| Chickenpox (Varicella) | ❑ No ❑ Yes, year: | Hepatitis A | ❑ No ❑ Yes, year: |
| COVID-19 Initial Dose | ❑ No ❑ Yes, year: | Hepatitis B | ❑ No ❑ Yes, year: |
| COVID-19 Booster | ❑ No ❑ Yes, year: | Meningococcal | ❑ No ❑ Yes, year: |
| Flu | ❑ No ❑ Yes, year: | Shingles | ❑ No ❑ Yes, year: |
| Gardasil (HPV) | ❑ No ❑ Yes, year: | Tetanus | ❑ No ❑ Yes, year: |
| Pneumonia | ❑ No ❑ Prevnar 13, year: | ❑ Prevnar 20, year: | ❑ Prevnar 23, year: |
| Other: | | | |

**PERSONAL & FAMILY HEALTH HISTORY**

**Place a check mark in the appropriate column if YOU or any of your IMMEDIATE RELATIVES (parents, children, brothers or sisters) currently have or have had any of these conditions:**

| CONDITION | | | | | |
|---|---|---|---|---|---|
| AIDS | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Hepatitis (If so, what type: A, B, C, other?) | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Alcohol addiction or other alcohol problems | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | High blood pressure | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Any other cancer, lymphoma, leukemia, etc. | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | High Cholesterol | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Asthma, COPD or emphysema | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | HIV positive | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Attention deficit hyperactivity disorder (ADHD) | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Hormone replacement therapy | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Bipolar disorder | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Kidney failure | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Bleeding or hemophilia | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Kidney stones | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Bleeding ulcers or stomach ulcers | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Low or high thyroid levels | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Blood clots | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Migraines | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Breast cancer | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Obesity | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Cervical cancer | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Ovarian cancer | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Chemical dependence or substance abuse | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Polycystic kidneys | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Colitis or inflammatory bowel disease | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Positive test for syphilis/STI (herpes, gonorrhea) | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Colon cancer | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Prostate cancer | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Colon polyps | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Rheumatoid arthritis or lupus | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Depression requiring counseling or treatment | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Schizophrenia | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Diabetes | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Skin cancer (any type) | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Epilepsy or seizure disorder | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Sleep apnea | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| GERD | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Tuberculosis | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Gout | ❑ Self ❑ Father ❑ Sibling ❑ Mother | | Heart attack, coronary bypass surgery, stent placement | ❑ Self ❑ Father ❑ Sibling ❑ Mother | |
| Other conditions not listed above: | | | | | |

NEW PATIENT HEALTH HISTORY

PETERSON HEALTH

PATIENT NAME (IN FULL) DATE OF BIRTH: TODAY'S DATE:

| YOUR HOME AND YOUR SOCIAL SYSTEMS | | |
|---|---|---|
| Do you drink alcohol? | ❑ No ❑ Yes, specify: | Drinks per week: |
| Do you currently use tobacco? | ❑ No ❑ Yes, specify: | Quantity per day: |
| Did you previously use tobacco? | ❑ No ❑ Yes, year quit: | Years smoked: |
| Have you ever used illicit drugs? | ❑ No ❑ Yes, specify: | Last used: |
| What is your highest level of education? | | |
| What is your current occupation? | | |
| Marital Status: ❑ Married ❑ Single ❑Divorced ❑Separated ❑Widowed ❑ Domestic Partner | | |
| Are you sexually active? | ❑ No ❑ Yes | Partners within the last year: |
| Are you able to care for yourself? | ❑ No ❑ Yes | |
| Do you have a Living Will? | ❑ No ❑ Yes | |
| Do you have an Advance Directive? | ❑ No ❑ Yes | |
| Do you have a MPOA? | ❑ No ❑ Yes | |
| Are you following a certain diet? | ❑ No ❑ Yes, specify: | |
| What is your exercise level? | ❑ None ❑ Occasional ❑ Moderate ❑ Heavy | |
| What type of exercise do you perform? | | |
| How often do you perform this exercise? | | |
| Do you have a religious preference? | ❑ No ❑ Yes, specify: | |

| SURGICAL OPERATIONS OR HOSPITALIZATIONS | | | | | |
|---|---|---|---|---|---|
| SURGERY | WHO/FACILITY | YEAR | SURGERY | WHO/FACILITY | YEAR |
| ❑ Appendectomy | | | ❑ Hysterectomy | | |
| ❑ Cataract | | | ❑ Remove ovary(ies) | | |
| ❑ Gallbladder | | | ❑ Spine/Neck | | |
| ❑ Heart | | | ❑ Tubal Ligation | | |
| ❑ Hernia (what kind?) | | | ❑ Vasectomy | | |
| ❑ Hip or knee | | | ❑ Other | | |
| Hospitalizations unrelated to surgeries above: | | | | | |

| HEALTH MAINTENANCE | | | |
|---|---|---|---|
| SCREENING TEST | | | |
| Eye exam | ❑ No ❑ Yes, year: | Bone Density (Dexascan) | ❑ No ❑ Yes, year: |
| Colonoscopy | ❑ No ❑ Yes, year: | Mammogram | ❑ No ❑ Yes, year: |
| Pap Smear | ❑ No ❑ Yes, year: | Prostate Exam | ❑ No ❑ Yes, year: |

| PHYSICIANS AND SPECIALISTS | | |
|---|---|---|
| List any other physicians below (i.e., Generalist, gynecologist, dermatologist, orthopedics, urologist, psychiatrist, etc. | | |
| PHYSICIAN NAME | SPECIALTY | CONDITIONS TREATED |
| | | |
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# Authorization to Use or Disclose Medical Records

PETERSON HEALTH

| Patient Name: | | Patient Date of Birth: | |
|---|---|---|---|
| Patient Address: | City: | State: | Zip Code: |

| Person or Entity Authorized to **RELEASE INFORMATION**: | Person or Entity Authorized to **RECEIVE INFORMATION**: |
|---|---|
| Name: _____<br>Address: _____<br>City, State, Zip Code: _____<br>Phone Number: _____<br>Fax Number: _____ | Name: _____<br>Address: _____<br>City, State, Zip Code: _____<br>Phone Number: _____<br>Fax Number: _____ |

**Specific information to be disclosed**:

❑ Medical record from (insert date) _____ to (insert date) _____

❑ **ENTIRE** medical record, **INCLUDING** patient histories, office notes (except psychotherapy notes and inclusions not chosen below), test results, radiology studies, referrals, consults, and records received from other providers.

❑ Other medical records (specify): _____

| Include (Indicate by checking **AND** initialing): | Reason for release of information (check all that apply): |
|---|---|
| ❑ _____ Drug/alcohol/substance abuse records<br>❑ _____ Mental health records (except psychotherapy notes)<br>❑ _____ HIV/AIDS information (Including HIV/AIDS tests and/or results)<br>❑ _____ Genetic information | ❑ Continuation of medical care<br>❑ Personal use<br>❑ Legal purposes<br>❑ Insurance purposes<br>❑ Other (specify): _____ |

This authorization shall remain in effect until for 12 months from the date signed or on the following specified date:
Month: _____ Day: _____ Year: _____

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

My signature indicates I have read and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

| _____<br>Patient Signature/Legally Authorized Representative | _____<br>Relationship to Patient | _____<br>Today's Date |
|---|---|---|

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

| _____<br>Signature of Minor Patient | _____<br>Printed Patient Name | _____<br>Today's Date |
|---|---|---|
| _____<br>Witness Signature | _____<br>Printed Witness Name | _____<br>Today's Date |