

Registration Form
Please Print Clearly



Chart # _____

Patient Information

Last Name: _____ First Name: _____ MI: _____

Other/Maiden/AKA Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best time to call: _____

Birth date: _____ Sex: Male _____ Female _____

Marital Status: Single _____ Married _____ Social Security #: _____ - _____ - _____

Email address: _____

Race: Caucasian (White) _____ Afro-American (Black) _____ American Indian/Alaska Native _____
Asian _____ Native Hawaiian _____ Pacific Islander (other than Hawaiian) _____
Whites of Latino/Hispanic descent _____ Blacks of Latino/Hispanic descent _____
American Indian of Latino/Hispanic Descent _____ More than One Race _____ Refuse to Report _____

Preferred Language: English Spanish Other: _____

Preferred Pharmacy: _____

Are you a veteran of the United States Armed Forces? Yes No

Responsible Party Information

Last Name: _____ First Name: _____

Birth date: _____ Social Security #: _____

Phone number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information

Last Name: _____ First Name: _____

Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell or Work Phone: _____

Insurance Information

Do you have insurance? Yes No

Primary Insurance Company _____

Secondary Insurance Company _____

Patient's Name: _____ Date of Birth: _____ Chart #: _____

If extra space is needed for any question, please continue on the back side of this form.

Purpose of Today's Visit

1. _____

Please list all current medications:

Name: _____ Strength: _____ Frequency: _____

For: _____

Name: _____ Strength: _____ Frequency: _____

For: _____

Name: _____ Strength: _____ Frequency: _____

For: _____

Medical History

Which of the following conditions are YOU currently being treated or have been treated for in the past?

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Pain (Specify: _____) |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Problems (Specify: _____) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Mental Health (Specify: _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other (Specify: _____) |

Allergies

Do you have any allergies (please check)? Penicillin Latex Other (Specify: _____) None

Past Surgeries

Surgery: _____ Date: _____ Surgery: _____ Date: _____

Surgery: _____ Date: _____ Surgery: _____ Date: _____

Hospitalizations

Date (Mo/Yr): _____ For: _____

Date (Mo/Yr): _____ For: _____

Family History

Has any member of your immediate family had any of the following serious illnesses? (Indicate who on the line.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Blood Disorder _____ | <input type="checkbox"/> Thyroid Problems _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Heart Problems _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Mental Health (Specify) _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Other (Specify) _____ | |

Social and Preventative History:

Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No

Are you exposed to smoke in the home? Yes No If no, have you been in the past? Yes No

Do you drink alcohol? Yes No If no, have you in the past? Yes No

Do you use illegal drugs? Yes No If no, have you in the past? Yes No

Have you been exposed to STDs? Yes No

Learning Needs Assessment:

May we leave detailed messages on your phone? Yes No

Do you speak English in your home? Yes No If no, what language do you speak? _____

Do you read and write English? Yes No

Do you see well? Yes No If no, do you use glasses or contacts? Yes No

Do you hear well? Yes No If no, do you use a hearing device? Yes No

Do you have any cultural or religious practices or beliefs that may affect your care or treatment? Yes No

If yes, please specify: _____

How do you like to learn new things? (Check all that apply)

- Reading Discussion Video Demonstration / Hands-on Self study Other: _____

Payment is due at the time of service. Please read and sign the following:

Sliding Fee Discount For Service

I understand that in order to receive the federal sliding fee discount for services at Family Healthcare, I must provide proof of income for all wage earners in my household. I understand that all sources of income, including wages, unemployment, social security, retirement, alimony, child support and disability income will be included. I understand that proof of income is required and can include check stubs, letters from employers, statement from person(s) providing your support, copies of income tax information and/or documents from government services. If I do not provide proof of income now, **I must bring my income proof to Family Healthcare within 7 days.** I also understand that my eligibility to receive medical care at a reduced rate will be reviewed every 6 months.

I understand that proof of income allows me to receive discounted services. I know that I will pay a co-pay for each visit and may be charged more depending on the services received.

I understand that if I have insurance, Family Healthcare may be able to discount services that are not covered by my insurance policy with proof of income.

Financial Agreement and Release of Information

I authorize Family Healthcare (Southwest Utah Community Health Center) to bill my insurance carrier for services rendered. I also authorize Family Healthcare to release all or part of the patient's record to any person or organization liable for payment. I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to Family Healthcare (Southwest Utah Community Health Center). **I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.**

Consent for Treatment

I authorize any Family Healthcare licensed healthcare provider to perform such diagnostic, medical, and/or surgical procedures as may be necessary for proper health care. I also give permission for administration of medications and immunizations as may be necessary for that treatment.

I have read all of the information on this registration form and have completed it to the best of my ability. I certify that this information is true and correct to the best of my knowledge. I understand that proof of the above information may be required at any time for any reason. If found ineligible, I may be subject to immediate termination of services and/or prosecution for fraud/perjury. I will notify Family Healthcare of any changes in my health status or any of the above information.

Signature (Patient/Legal Representative)

Date



NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

Effective Date: April 14, 2003

Please review the Notice of Privacy Practices carefully.

The Notice of Privacy Practices tells you how Family Healthcare may use or disclose information about you. Not all situations will be described. Family Healthcare is required to inform you of our privacy practices for the information we collect and keep about you.

OPTIONAL DISCLOSURE:

I hereby authorize Family Healthcare to disclose my medical information to

_____ (name)

I understand they will have to access my medical record, both verbally and written.

I have been given a copy of Family Healthcare's Notice of Privacy Practices and have had a chance to ask questions about how my information should be used.

Signature (Patient/Legal Representative)

Date

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

By signing below, I authorize Family Healthcare and its affiliated providers to view my external prescription history. I understand that prescription history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff at Family Healthcare, and it may include prescriptions over several years.

My signature certifies that I have read and understood the scope of my consent and that I authorize the access to my prescription history.

Signature (Patient/Legal Representative)

Date