# WINDROSE FAMILY MEDICINE
# PATIENT REGISTRATION FORM (eCW)

**PATIENT INFORMATION** (Please print)

Patient's Name: (Last)_____(First)_____(MI) _____

Address: _____

City, State, Zip: _____

Home:_____Cell:_____Work: _____

E-Mail Address:_____DOB: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Sex: ☐ Female ☐ Male ☐ Transgender
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined
Language: ☐ English ☐ Spanish ☐ Indian: Hindi, etc. ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined
Social Security Number:_____-_____-_____

**RESPONSIBLE PARTY INFORMATION (*If not self*)** (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Social Security Number:_____-_____-_____ Phone number: _____
Address: _____
City, State:_____ZIP: _____

**INSURANCE INFORMATION:** Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

**EMERGENCY CONTACT INFORMATION**

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address _____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

**GENERAL CONSENT FOR CARE AND TREATMENT CONSENT**

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

## Health History

Name: _____ Date of birth: _____ Height: _____ Weight: _____

Reason for visit today: _____

☐ ☐

**Are you allergic to any medications? Yes or No (If yes, please list.)**

| Allergic to the following medications | Type of Allergic Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**List the name and dosage of the medications you are currently taking:**

| Current Medications | Dosage |
|---|---|
| | |
| | |
| | |
| | |
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| | |

**Pharmacy information:**

Name: _____ Phone number: _____

Address: _____

**Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

**Employment Status:** ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired

**Occupation:** _____

**Last colonoscopy Date**: _____

**Last Flu Vaccine**: _____ **Last Pneumonia Vaccine**_____ **Last Shingles Vaccine**_____

**How did you hear about us? Circle any that apply:**

☐ Website ☐ Family/Friend ☐ Internet Search ☐ Other_____

**FOR FEMALES ONLY:**

Age at First Period_____

Date of Last Menstrual period_____

Date of last mammogram_____

Date of Last Pap Smear:_____

Any History of abnormal pap smears? ☐ Yes ☐ No If so When_____

Are periods regular? ☐ Yes ☐ No

Do you have pain with periods? ☐ Yes ☐ No

Is Flow: ☐ Normal ☐ Heavy ☐ Light ☐ Spotting

Number of Pregnancies_____

Number of Live Children_____

Number of miscarriages _____

Number of Abortions_____

**Clinical Use Only: Height**_____ Weight_____Temp_____BP:_____Pulse:_____Resp:_____Pulse OX:_____ Peak Flow:_____

## Medical History

Name: _____ Date of Birth: _____

Please provide your **PAST MEDICAL HISTORY:**

- ____ Allergies
- ____ Anemia
- ____ Angina (chest pain)
- ____ Anxiety
- ____ Arthritis
- ____ Asthma
- ____ Atrial fibrillation
- ____ BPH (enlarged prostate)
- ____ Blood clots
- ____ Cancer, Type ____
- ____ CVA (stroke)
- ____ COPD (emphysema)
- ____ CAD (heart disease)
- ____ Crohn's disease
- ____ Depression
- ____ Diabetes
- ____ Gallbladder disease
- ____ GERD (reflux)
- ____ Hepatitis C
- ____ High cholesterol
- ____ High blood pressure
- ____ Irritable bowel syndrome
- ____ Liver disease
- ____ Migraine headaches
- ____ MI (heart attack)
- ____ Osteoarthritis
- ____ Osteoporosis
- ____ Peptic ulcer disease
- ____ Renal disease (kidneys)
- ____ Seizure disorder
- ____ Thyroid disease
- ____ AIDS/HIV

Please tell us about any **SURGERIES** you have had, and indicate the **DATE/YEAR** if known:

- ____ Angioplasty
- ____ Colostomy
- ____ Appendix
- ____ Arthroscopy knee
- ____ Back surgery
- ____ CABG (open heart surgery)
- ____ Carpal tunnel release
- ____ Cataract
- ____ Cholecystectomy (gallbladder)
- ____ Eartube/BMT
- ____ Colectomy (colon removed)
- ____ Small bowel resection
- ____ Gastric bypass
- ____ Hernia repair
- ____ Hip replacement
- ____ Knee replacement
- ____ LASIK
- ____ Liver biopsy
- ____ Mastoidectomy
- ____ Pacemaker
- ____ Thyroidectomy
- ____ Tonsillectomy
- ____ Tympanoplasty

**Gender Specific Male:**

- ____ Prostatectomy
- ____ TURP
- ____ Vasectomy

**Gender Specific Female:**

- ____ Breast augmentation
- ____ Bilateral tubal ligation
- ____ Breast biopsy
- ____ Cesarean section
- ____ D & C
- ____ Hysterectomy
- ____ Mastectomy
- ____ Breast reduction

Please list any **ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:**

_____
_____
_____

Please provide your **FAMILY HISTORY:**

| | Mother | Father | Sister | Brother | Other |
|---|---|---|---|---|---|
| ADD/ADHD | | | | | |
| Alcoholism | | | | | |
| Allergies | | | | | |
| Alzheimer's disease | | | | | |
| Asthma | | | | | |
| Blood disease | | | | | |
| Coronary artery disease (heart disease) | | | | | |
| Premature heart disease (male <55 yr, female <65 yr) | | | | | |
| Cancer, Type_____ | | | | | |
| CVA (stroke) | | | | | |
| Depression | | | | | |
| Developmental delay | | | | | |
| Diabetes | | | | | |
| Eczema | | | | | |

| | Mother | Father | Sister | Brother | Other |
|---|---|---|---|---|---|
| Hearing deficiency | | | | | |
| High cholesterol | | | | | |
| High blood pressure | | | | | |
| Irritable bowel syndrome | | | | | |
| Learning disability | | | | | |
| Mental illness | | | | | |
| Migraines | | | | | |
| Obesity | | | | | |
| Osteoarthritis | | | | | |
| Osteoporosis | | | | | |
| Peripheral vascular disease (blood clots) | | | | | |
| Renal (kidney) disease | | | | | |
| Seizure disorder | | | | | |
| Other: _____ | | | | | |

Please provide your **SOCIAL HISTORY:**

Do you smoke? YES☐ NO☐ FORMER☐

Type of tobacco: _____
Packs per day: _____
Years smoked: _____
Year quit: _____
Have you ever tried to quit? ☐YES ☐NO

Do you drink alcohol? ☐YES ☐NO ☐FORMER

Type of alcohol: _____
Frequency: _____
Amount: _____
When was your last drink? _____

Patient name: _____

Date of birth: _____

**Patient Consent for Financial Communications**

**Financial Agreement**

- I acknowledge, that as a courtesy, WINDROSE FAMILY MEDICINE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

**Third Party Collection**. I acknowledge WINDROSE FAMILY MEDICINE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

**Assignment of Benefits.** I hereby assign to WINDROSE FAMILY MEDICINE any insurance or other third-party benefits available for health care services provided to me. I understand WINDROSE FAMILY MEDICINE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to WINDROSE FAMILY MEDICINE) I agree to forward all health Insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

**Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to WINDROSE FAMILY MEDICINE by the Medicare or Medicaid program.

**Consent to Telephone Calls for Financial Communications.** I agree that, in order for WINDROSE FAMILY MEDICINE or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that WINDROSE FAMILY MEDICINE or EBO Servicer And collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or WINDROSE FAMILY MEDICINE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre- recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

**Patient/patient representative signature:**_____ **Date:** _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse ☐ ☐ Guarantor

Parent ☐ ☐ Healthcare Power of Attorney

Legal Guardian ☐ ☐ Other (please specify) ☐

# Patient HIPAA Acknowledgment and Consent Form

| Location Name | | | |
|---|---|---|---|
| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
| | | | |

**Notice of Privacy Practice/clinics**

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

**Disclosures to Friends and/or Family Members**

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

| | Name | Relationship | Contact Number |
|---|---|---|---|
| 1: | | | |
| 2: | | | |
| 3: | | | |

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

**Communications about My Healthcare**

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

**Consent for Photographing or Other Recording for Security and/or Health Care Operations**

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinics health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications**

**If at any time I provide an email address or cellphone number** at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Note:** This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

# Patient HIPAA Acknowledgment and Consent Form

| Location Name | | | |
|---|---|---|---|
| Patient Last Name (Printed) | Patient First Name (Printed) | MI | Date of Birth (MM/DD/YYYY) |
| | | | |

**Release of Information.**

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

| Patient/Representative Signature | Relationship to Patient (self, parent, legal guardian/representative, etc) | Date |
|---|---|---|
| | | |

**Prescription Order Pick-up.** There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

| NAME | Relationship to Patient |
|---|---|
| | |
| | |

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.