PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last)	(First)	(Middle)	(Jr, Sr, etc.)

Gender	Social Security Number	Marital Status	Date of Birth
☐Male ☐Female		☐Single ☐Married ☐Divorced ☐Separated	/ /

What is your race?	What is your Ethnicity?	What is your primary language?	Who is your provider at CHS?
☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American ☐American Indian/Alaska Native ☐White ☐More than one race ☐Other	☐Hispanic/Latino ☐Not Hispanic/Latino	☐English ☐Spanish ☐Other___________________	

Full Address (Street or P.O. Box)	(City)	(State)	(Zip)
Apt.#:			

Home Phone Number	Cell Phone Number	Work Phone Number	Email Address
( )	( )	( ) Ext.	

Please be prepared to present your insurance card, photo identification and proof of income documentation, if necessary.

RESPONSIBLE PARTY *(Complete if different from above)*

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Grandchild ☐Foster Child ☐Guardian ☐Mother ☐Father ☐Other________________________________

Name of Responsible Party (Last)	(First)	(Middle)	(Jr, Sr, etc.)

Date of Birth	Gender	Social Security Number	Marital Status
/ /	☐Male ☐Female		☐Single ☐Married ☐Divorced ☐Separated

Home Phone Number	Work Phone Number	Cell Phone Number	Email Address
( )	( ) Ext.	( )	

Full Address (Street or P.O. Box)	(City)	(State)	(Zip)
Apt.#:			

INSURANCE INFORMATION *(If uninsured, please be prepared to present proof of income to qualify for discount program.)*

Primary Insurance (Carrier Name)	Insurance Address	Phone Number
		( )

Policy Holder ID (Subscriber ID)	Group #	Subscriber Name	Relation to Patient:	Co-Pay ($)
			☐Self ☐Spouse ☐Child ☐Other__________________	

Secondary Insurance (Carrier Name)	Insurance Address	Phone Number
		( )

Policy Holder ID (Subscriber ID)	Group #	Subscriber Name	Relation to Patient:	Co-Pay ($)
			☐Self ☐Spouse ☐Child ☐Other__________________	

If you have more than two insurances, please provide the additional information at the time of registration.

ADDITIONAL REQUIRED INFORMATION

Emergency Contact (Name)	(Address)	(Phone)	Relation to Patient

HOW CAN WE BE PRAYING FOR YOU TODAY?

AUTHORIZATION AND ASSIGNMENT

I do hereby voluntarily consent to medical care at Crossover Health Services (CHS). I hereby authorize all physicians and their assistants including Physician Assistants and Nurse Practitioners employed by CHS to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I also assign the claim payments to be made payable to CHS. I agree to the release of information to Medicare, SoonerCare and third party payors. I understand that some of the services that may be ordered may not be covered under Medicare, SoonerCare and other insurance and that I am responsible for any amount that is not paid. THIS AUTHORIZATION AND ASSIGNMENT IS A PERMANENT ONE-TIME SIGNATURE WHICH WILL REMAIN ON FILE AND WILL BE USED FOR FUTURE CLAIMS. I MAY REVOKE IT AT ANY TIME BY WRITTEN NOTICE.

Signature of Patient/Responsible Party: ____ **Date:** ___________________________

Adult Medical Profile

PATIENT NAME IN FULL	☐ M ☐ F	AGE	VISIT DATE / DATE OF BIRTH

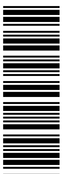
MARITAL STATUS	OCCUPATION

PERSONAL AND FAMILY HISTORY

- Indicate if you or anyone in your family has (or has ever had) any of the following conditions
- If a member of your family has had one of these conditions, indicate their relationship to you

DESCRIPTION	PERSONAL YES	PERSONAL NO	FAMILY YES	FAMILY NO	RELATION	DESCRIPTION	PERSONAL YES	PERSONAL NO	FAMILY YES	FAMILY NO	RELATION
Hearing problems						High cholesterol					
Heart disease / Circulatory problems						Epilepsy or seizures					
High blood pressure						Migraine headaches					
Stroke						Arthritis or Gout					
Asthma, emphysema, bronchitis						Depression / nervous problem					
Ulcers / Digestive problems						Diabetes					
Drug / Alcohol problems						Hepatitis or liver problems					
Cancer: Breast						Thyroid disease					
Colon						Sleep apnea					
Prostate						Anemia / Blood diseases					
Other, where?						HIV / AIDS / STDs					
Kidney stones/cysts/failure						Tuberculosis					
Other:						Osteoporosis					

For each personal medical condition listed above, please indicate the year when it started



Social History

INDICATE USAGE			
Tobacco ☐ No ☐ Yes	PACKS OR CANS PER DAY	FOR HOW MANY YEARS	DATE QUIT
Alcoholic Beverages ☐ No ☐ Yes	FREQUENCY		AMOUNT
Caffeinated Beverages ☐ No ☐ Yes	TYPE		CAFFEINE PER DAY

TOTAL NUMBER OF CHILDREN IN THE HOME	Childbirth History	# OF PREGNANCIES	# OF LOST PREGNANCIES #	ANY COMPLICATIONS OF PREGNANCY

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TESTS

HOSPITALIZATION / SURGERY / DIAGNOSTIC TEST	DATE	HOSPITALIZATION / SURGERY / DIAGNOSTIC TEST	DATE

DRUG REACTIONS

Have you ever had a bad reaction to a drug that you have taken? ☐ No ☐ Yes

Name of drug:				
type of reaction:				

IMMUNIZATIONS

TYPE OF IMMUNIZATION	DATE	OTHER IMMUNIZATIONS	DATE
Last Pneumonia		Hepatitis A	
Last Tetanus		Hepatitis B	
Last Influenza		Varicella (shingles)	
Last TB Skin Test		Other (HPV, meningococcal, etc.)	

If under 18, are immunizations current ☐ Yes ☐ No

On the back of this form please write the names of any medications you take, how often you take them, and their dosages

Name: ______________________________ Date: ______________

Ht: BP: Pulse:
Wt: BS: O2:
LMP:

Pharmacy:

General-
- ☐ Weight loss or gain
- ☐ Excessive tiredness
- ☐ Persistent fever or chills
- ☐ Loss of strength
- ☐ Trouble sleeping

Eyes-
- ☐ Vision Loss/vision changes
- ☐ Blurry or double vision
- ☐ Tearing or redness
- ☐ Flashing lights or specks
- ☐ Pain
- ☐ Glaucoma
- ☐ Cataracts

Head-
- ☐ Headache
- ☐ Head injury (explain):
- ☐ Neck Pain

Ears-
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache

Nose-
- ☐ Stuffiness
- ☐ Sinus pressure
- ☐ Drainage
- ☐ Itching
- ☐ Nosebleeds

Throat & mouth
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Sore throat or tongue
- ☐ Dentures
- ☐ Dry mouth
- ☐ Recurrent sores or ulcers

Skin-
- ☐ Changing spots on skin
- ☐ Itching
- ☐ Rash
- ☐ Color changes
- ☐ Acne
- ☐ Hair and nail changes

Respiratory-
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Sputum production
- ☐ Coughing up blood
- ☐ Painful breathing
- ☐ Sudden awakening from sleep with snoring or shortness of breath
- ☐ Positive Tb skin test

Cardiovascular-
- ☐ Chest pain, chest tightness, or discomfort
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Poor circulation
- ☐ Difficulty breathing lying down
- ☐ Swelling

Gastrointestinal-
- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Rectal bleeding
- ☐ Abdominal pains
- ☐ Change in bowel habits
- ☐ Yellow eyes or skin
- ☐ Incontinence

Urinary-
- ☐ Frequency
- ☐ Burning or pain
- ☐ Urgency
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Change in urinary strength

For men-
- ☐ Erectile dysfunction
- ☐ Sex with men

Musculoskeletal-
- ☐ Muscle pain
- ☐ joint pain
- ☐ Leg cramping or restlessness
- ☐ Stiffness
- ☐ Injuries (explain):
- ☐ Redness or swelling of joints
- ☐ Back pain
- ☐ Sciatica
- ☐ Calf pain with walking

Neurologic-
- ☐ Dizziness or balance problems
- ☐ Fainting
- ☐ Seizures
- ☐ Tingling or numbness
- ☐ Paralysis
- ☐ Tremor

Psychiatric-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Troubling thoughts
- ☐ Memory loss or confusion

Hematologic-
- ☐ History of anemia
- ☐ Ease of bruising or bleeding
- ☐ Swollen glands

Endocrine-
- ☐ Heat or cold intolerance
- ☐ Abnormal hair growth
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Allergy-
- ☐ Drug allergy:
- ☐ History of steroid use

For women-
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Breast pain
- ☐ Doing breast self-exams
- ☐ Breast-feeding
- ☐ Menstrual period irreularities
- ☐ Pelvic pain
- ☐ Vaginal discharge or itching

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ______________________________________date____________do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.