Patient Registration Form

Please clearly print your response to all requested information. If you have questions, please ask.

Patient Information:

Patient's Full Name: ____

Address: ____

Home Phone: ______________________ Cell: _________________________ Work: ______________________

DOB: _____/______/________ (mm/dd/yyyy) Age: ______ Occupation Status: ______________________

Marital Status: (circle one) Single/Married/Divorced/Widowed | Sex: (circle one) Female Male Non-Binary Transgender

Race: (circle one) White Black or African American American Indian or Alaska Native Native Hawaiian or Pacific Islander Asian Other: ______________

Ethnicity: Hispanic or Latino | Not Hispanic or Latino

Responsible Party Information: if the patient is a minor (under the age of 18), the parent or guardian brining the patient will be listed as the guarantor

Name: ____

Address: ____

Relationship to Patient: ____________________ Phone: ______________________ (Home, Work, Cell)

DOB: _____/______/________ (mm/dd/yyyy) Email Address: ____

Pharmacy:

Preferred Pharmacy Name: _______________________ Pharmacy Address: ____

Pharmacy Phone: ________________________________

Insurance Information:

Primary Insurance	Secondary Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Ins. ID#:	Ins. ID#:
Ins. Group#:	Ins. Group#:
Ins. BIN#:	Ins. BIN#:
Ins. PCN#:	Ins. PCN#:

Emergency Contact:

Emergency Contact Name: ____ Relationship to Patient: ____________________

Emergency Contact Address: ____

Home #: __________________________ Work #: __________________________ Cell #: __________________________

Additional Information:

Preferred Method of Contact for reminder calls and other electronically generated messages: (circle one) Voice or Text

If voice, please select preferred number: (circle one) Home Cell Work

Can we leave a message regarding your medical care & test results? (circle one) Yes No

Patient Medical History Form

Patient's Full Name: ____ Date: _________________________________

What is the reason for your visit today? ____

____

Please List all your Medical Problems (current & old) ____

____

Please list current medication: ____

____

____

Please List all your Previous Surgeries____

Medical History: (please check appropriate box)

☐ADD/AHDA	☐ Allergic Rhinitis
☐Anemia	☐ Asthma/Emphysema
☐Congenital Heart Disease	☐ Constipation
☐ Developmental Delay	☐ Diabetes
☐ Eczema	☐ Mental illness
☐ GE Reflux	☐ Recurrent Strep Throat
☐ Murmur	☐ Vision Problems
☐ Recurrent Otitis (ear infections)	☐ Wheezing/RSV/Bronchiolitis
☐ Seizures	☐ UTI
☐ Vesicoureteral Reflux	☐ Autism/Asperger's Disorder
☐ Learning Problem	☐ Concussion
☐ Failure to thrive/poor growth	☐ Chronic abdominal pain
☐ Headache	☐ High Blood Pressure
☐ Shortness of Breath	☐ Blood with Coughing
☐ Anesthetic Reaction	☐ Thyroid Disease
☐ Arthritis	☐ Kidney Stones
☐ Blood in Urine	☐ Frequent Urination
☐ Pain with Urination	☐ Depression
☐ Stroke	☐ Nervous Disorder
☐ Back Pain	☐ Blood Transfusion
☐ HIV/AIDS	☐ Hepatitis
☐ Bleeding Tendency	☐ Diarrhea
☐ Constipation	☐ Stomach Ulcers
☐ Heartburn	☐ Hernia Repairs
☐ Cancers:	☐ Migraine Headache
☐ COVID-19	☐ Lightheadedness
☐ Bronchitis	☐ T.B.
☐ Indigestion	☐ Blood in Stool
☐ Unexplained weight loss/gain	☐ Sexually Transmitted Disease
☐ Anxiety	☐ Alcohol Abuse
☐ Gout	☐ Sleep Problem
☐ Nausea/Vomiting	☐ Colitis
☐ kidney disease	☐Difficulty holding urine
☐ Difficulty passing urine	
☐ Hyperlipidemia	

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Patient Medical History Form

Any additional medical history not listed please provide:

____

____

____

Allergies: (allergies tested by blood or skin testing)

Medication/Drug Allergies:____

____

Food Allergies (do you carry a current EpiPen?): ____

____

Seasonal allergies: ____

____

Family Medical History: list and check yes or no below if any family members who have had the following illnesses.

(family members are your mother, father, grandparents, siblings, aunts, uncles)

Condition	Yes / No	Family Member
Allergies	☐Yes ☐No	
Anemia	☐Yes ☐No	
Arthritis	☐Yes ☐No	
Asthma, Emphysema, T.B.	☐Yes ☐No	
Birth Defect	☐Yes ☐No	
Blood Disease	☐Yes ☐No	
Bone/Muscle Disease	☐Yes ☐No	
Cancer (specify)	☐Yes ☐No	
Cystic Fibrosis	☐Yes ☐No	
Diabetes ☐Adult ☐Juvenile	☐Yes ☐No	
Drug/Alcohol Abuse	☐Yes ☐No	
Eye/Ear Disorders	☐Yes ☐No	
Heart Disease	☐Yes ☐No	
High Blood Pressure	☐Yes ☐No	
Infections (Frequent/Serve)	☐Yes ☐No	
Kidney/Liver Disease	☐Yes ☐No	
Learning Problems	☐Yes ☐No	
Mental Illness/Retardation	☐Yes ☐No	
Metabolic/Genetic Disease	☐Yes ☐No	
Nerve Disorder (Epilepsy, C.P.)	☐Yes ☐No	
Rheumatic Fever	☐Yes ☐No	
Sickle Cell Trait/Disease	☐Yes ☐No	
TB or Exposure	☐Yes ☐No	
Thyroid Disease	☐Yes ☐No	
Autoimmune Disease	☐Yes ☐No	
Skin Disease (eczema, psoriasis)	☐Yes ☐No	
Heart Attack <50 years old	☐Yes ☐No	

Any additional medical history not listed please provide:

____

____

CONSENT FOR TREATMENT

I, ____, authorize and direct the licensed practitioners and staff of Amazing Health Partners Clinic to render medical care as determined necessary at the time of service.

Patient Signature: ____ **Date:** ________________

Witness Signature: ____ **Date:** ________________

If patient is a minor or unable to sign:

Name of Person Giving Consent: ____________________________________

Relationship to Patient: ____

Witness Signature: ____ **Date:** ________________

CONSENT TO RELEASE MEDICAL INFORMATION

I, ____, give the physicians and staff of Amazing Health Partners Clinic permission to discuss all aspects of my personal health history, condition, and treatment with my:

Spouse: __________________________________ **other:** __________________________________

Parent: __________________________________ **Guardian:** _________________________________

Patient Signature: ____ **Date:** ________________

Witness Signature: ____ **Date:** ________________

HIPAA Acknowledge and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from designated third-party payers.
Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of your *Notice of Privacy Practices* of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounded to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name (Print Name or Representative): ____

Relationship to Patient (If other than patient): ____

Patient's Signature: ____ Date: _________________

Witness Signature: ____ Date: _________________

Consent For Procedure

Patient's Name: _______________________________________ DOB: _________________

Procedure (to be completed by the doctor) ____

Procedure risks may include: Pain, minor bleeding, minor skin changes, and infections.

I have explained the procedure to the patient/patient's parent/guardian and the appropriate options that are available to

the patient. I have also discussed any particular concerns the patient may have.

PATIENT/PARENT/ GUARDIAN

1. Please read this form carefully and fill out the information on this form as appropriate.

2. If you have any further questions before the procedure or require any further information, please ask the doctor.

3. Please sign below if you wish to proceed with the procedure.

DECLARATION

I am the Patient/Patient's Parent/Patient's Guardian

I agree to the procedure as detailed above

I understand that the doctor who has been treating me so far may not carry out the procedure

I understand that this consent is only for the procedure detailed above and would not wish any further procedures to be carried out without having the opportunity to consider them first.

Patient's/Guardian Signature: _______________________________ Date: _________________

Doctor Signature: ____ Date: _________________

Cancellation And No-Show Policy

We have a waiting list for new patients as well as a full schedule of ongoing patient care appointments. To maximize efficient clinic operation, we make every effort to minimize last minute appointment cancellations. Out of respect for our professional staff and for patients waiting to obtain an appointment, we adopt these policies effective July 1, 2022.

Cancellation

We ask for a 24-hour notice of cancellation of your scheduled appointment. Failure to notify in advance will result in a $25 charge payable at your next schedule appointment. We do recognize that emergencies do occur and will determine when and if fees will be waived.

No shows

Any no shoes for a scheduled appointment will be charged $25 per occurrence. This cannot be billed to your insurance and will be due at the time of your next appointment.

Thank you for helping us be efficient in our scheduling and consideration of others, thank you for choosing Amazing Health Partners Clinic as your primary care provider.

Acknowledgement

I acknowledge that I have received and read a copy of the **Amazing Health Partners Clinic Cancellation and No-show policy.**

Patient's (print name): ____

Patient's Signature: ____ Date: _________________