MINDEN Physician Practices

PATIENT REGISTRATION FORM

Patient Legal Name: _____ Marital Status: _____

Birthdate: _____ Social Security #: _____-_____-_____ May we text you? □ Yes □ No

Street or Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address (Required for portal access) _____

May we email you educational information? □ Yes □ No

Occupation: _____ Employer: _____ Employer Phone #: _____

Race: _____ Ethnicity: _____ Language (if other than English): _____

Pharmacy: _____ Pharmacy City: _____

Referred by: □ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □ Yellow Pages □ Other: _____

Family Doctor Name: _____ Family Doctor Phone #: _____

Date of last visit with family doctor: _____

RESPONSIBLE PARTY INFORMATION

Are you responsible for the bill? □ Yes □ No □ Check here if person responsible for bill is same as patient

If not: Name of Responsible Person: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Employer: _____

Insurance Policyholder Name: _____ Birthdate _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone Number: _____

Next of Kin: _____Relationship: _____Phone Number: _ _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient|Guardian Signature: _____ Date|Time:_____

ADULT HEALTH FORM

REASON FOR VISIT: _____

PREFERRED PHARMACY: _____ **PHARMACY LOCATION:** _____

ALLERGIES: _____

LIST ANY CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL):

MEDICATION	DOSE (E.G. MG/PILL)	HOW MANY TIMES PER DAY?

PLEASE SELECT THE CONDITIONS BELOW THAT APPLY TO YOU OR A FAMILY MEMBER

PLEASE SPECIFY MATERNAL OR PATERNAL SIDE OF FAMILY AND RELATION TO YOU

Example: Paternal side, aunt; maternal side grandmother; brother/sister

	SELF	FAMILY Mother (M) Father (P) Relation to you		SELF	FAMILY Mother (M) Father (P) Relation to you
ADD or ADHD			Heart Problems		
Allergies			Hepatitis		
Anxiety Disorder			High Blood Pressure		
Arthritis			High Cholesterol		
Asthma			Kidney Problems		
Bipolar Disorder			Liver Disease		
Birth Defect or Inherited Disease			Mental Retardation (Chromosome Disorders)		
Breast Problems			Lung Problems		
Cancer			Osteoporosis		
Cystic Fibrosis			Psychiatric Illness		
Depression			Pulmonary Embolism		
Diabetes			Seizures/Epilepsy		
Diverticulitis			Skin Problems		
Endometriosis			Stroke		
Fibromyalgia			Thyroid Problems		
GERD/Reflux			Tuberculosis		
Headaches/Migraines			Varicose Veins		
Heart Disease			Vision or Eye Problems		

Any other conditions not listed above: _____

SOCIAL HISTORY:

(CIRCLE ONE) MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPERATED SINGLE WIDOWED

WHAT KIND OF WORK DO YOU DO: _____

HIGHEST GRADE YOU COMPLETED: _____

EXERCISE LEVEL: NONE OCCASIONAL, MODERATE, HEAVY

ALCOHOL INTAKE: NEVER OCCASIONAL DAILY

CAFFIENE INTAKE: NONE OCCASIONAL, MODERATE, HEAVY

SMOKING HISTORY: NEVER FORMER DAILY OCCASIONALLY

AMOUNT: _____ HOW MANY YEARS: _____

DO YOU VAP: YES OR NO CHEWING TABACCO: YES OR NO

HISTORY OF OR CURRENT DRUG USE: YES NO LIST ANY STREET DRUGS USED IN THE LAST YEAR: _____

DO YOU USE A SEATBELT ROUTINELY? YES NO DO YOU USE SUNSCREEN ROUTINELY? YES NO

WHO LIVES WITH YOU? _____ NUMBER OF CHILDREN IN THE HOUSE: _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL SEXUALLY ACTIVE: YES NO

HAVE YOU HAD THE INFULENZA VACCINE IN THE LAST YEAR? YES NO

HAVE YOU HAD THE PNUEMONIA VACCINE IN THE LAST 5 YEARS? (>65 YEARS OLD) YES NO

GYN HISTORY AND OBSTETRIC HISTORY:

LAST MENSTRUAL PERIOD_____

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ HOW MANY LIVING CHILDREN DO YOU HAVE? _____

SURGERIES (LIST TYPE OF SURGERY AND APPROXIMATE YEAR INCLUDING C-SECTION, TUBAL, D&C, BLADDER SUSPENSION):

Surgery Type	Surgery Year

List any hospitalizations not related to childbirth:

_____ _____

_____ _____

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Patient Name: _____ **Date of Birth:** _____ / _____ / _____

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

In your own words, describe the current problems as you see them:

_____

_____

_____

How long has this been going on? _____

What made you come in at this time?

_____

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

Symptoms (Please CHECK any symptoms or experiences that you have had in **the last month**)

___ Difficulty falling asleep ___ Difficulty staying asleep

___ Difficulty getting out of bed ___ Not feeling resting in the morning

Average hours of sleep per night: _____

___ Persistent loss of interest in previously enjoyed activities

___ Withdrawing from other people ___ Spending increased time alone

___ Depressed mood ___ Feeling Numb

___ Rapid mood changes ___ Irritability

___ Anxiety ___Panic Attacks

___ Frequent feelings of guilt ___Avoiding people, places, activities or specific things

___ Difficulty leaving your home

___ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____

___ Repetitive behaviors or mental acts (i.e., counting checking doors, washing hands)

___ Outburst of anger ___ Worthlessness

___ Hopelessness ___ Sadness ___ Helplessness

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___ Fear ___ Feeling or acting like a different person

___ Changes in eating/appetite ___ Eating more ___Eating less

___ Voluntary vomiting ___ User of laxatives ___ Binge eating

___ Excessive exercise to avoid weight gain

___ Are you trying to lose weight? ___ Weight gain: _____lbs. ___ Weight loss: _____lbs.

___ Difficulty catching your breath ___ Increase muscle tension ___ unusual sweating

___ Easily started, feeling "jumpy" ___ Increased energy ___ Decreased energy

___ Tremor ___ Dizziness ___ Frequent worry

___ Physical sensations others don't have ___Racing Thoughts ___ Intrusive memories

___ Difficulty concentrating or thinking ___ Large gaps in memory ___ Flashbacks

___ Nightmares

___ Thoughts about harming or killing yourself ___ Thoughts about harming or killing someone else

___ Feeling as if you were outside yourself, detached, observing what you are doing

___ Feeling puzzled as to what is real or unreal

___ Persistent, repetitive, intrusive thoughts, impulses, or images

___ Unusual visual experiences such as flashes of light, shadows

___ Hear voices when no one else is present

___ Feeling that your thoughts are controlled or placed in your mind

___ Difficulty problem solving ___ Difficulty meeting role expectations

___ Dependency on others ___ Manipulation of others to fulfill your own desires

___ Inappropriate expression of anger ___ Self-mutilation/cutting

___ Difficulty or inability to say "no" to others ___ Ineffective communication

___ Sense of lack of control ___ Decreased ability to handle stress

___ Abusive relationship ___ Difficulty expression emotions ___ Concerns about your sexuality

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Sexual Orientation: ___ Heterosexual ___ Homosexual ___ Bisexual ___ I choose not to answer

Please describe any other symptoms or experiences you have had problems with: _____

_____

_____

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Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

___ No ___ Yes If so:

Name of therapist: _____ Dates of Treatment:
Reason for seeking help: _____ _____
Name of therapist: _____ Dates of Treatment:
Reason for seeking help: _____ _____
Name of therapist: _____ Dates of Treatment:
Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ___ No ___ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ___ No ___ Yes If YES, please list:

Medication	Dosage	How long have you been taking it?	Has it been helpful?

Have you been on **PSYCHIATRIC** medication in the past? ___ No ___ Yes If YES, please list:

Medication	Dosage	First/Last time you took it	Effect of medication

Have you been hospitalized for psychiatric reasons? ___ No ___ Yes If YES, describe:

Hospital Name	Dates	Reason

Have you ever attempted suicide? ___ No ___ Yes If YES, describe: _____

_____

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MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ___ No ___ Yes If YES, describe:

_____

_____

_____

List any **PRIOR** illnesses, operations and accidents

_____

_____

_____

FAMILY HISTORY

Father: Age: _____ ☐Living ☐Deceased Cause of death: _____

If deceased, HIS age at time of his death: _____ YOUR age at time of his death: _____
Occupation: _____ Health: _____
Frequency of contact with him: _____ Are you/Have you been close to him? _____

Mother: Age: _____ ☐Living ☐Deceased Cause of death: _____

If deceased, HER age at time of her death: _____ YOUR age at time of her death: _____
Occupation: _____ Health: _____
Frequency of contact with her: _____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?
☐ No ☐ Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship: _____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

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SOCIAL HISTORY

Past Marital History: Have you been married previously? If YES, please describe

When? _____ How long? _____
When? _____ How long? _____

Education:

Highest grade level completed: _____ Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? ___ Yes ___ No
If yes, please explain: _____
Were you considered hyperactive/AHDH in school? ___ Yes ___ No
If yes, were/are you on any medication? ___ Yes ___ No
If so, which medication? _____
What kinds of grades did you get in school? _____

Have you served in the military? ___ Yes ___ No If yes, please describe briefly: _____
What type of discharge (separation) did you get? _____

Employment:

Are you currently employed? ___ Yes ___ No
If yes, employer's name: _____ What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for leaving

Have you been arrested? ___ Yes ___ No If yes, please describe: _____

Do you have a religious affiliation? ___Yes ___ No If yes, what is it? _____

What kind of social activities do you participate in? _____

Whom do you turn to for help with your problems? _____

Have you ever been abused? ☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected
Please describe:

_____

_____

Cultural Variables:

Does your cultural background, race, or religion effect the way you feel about yourself or towards to others?
___ Yes ___ No If yes, please describe: _____

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SUBSTANCE ABUSE

Alcohol and Tobacco:

Do you drink alcohol? ___ Yes ___ No If yes, age of first use: _____
How much do you drink? _____
How often do you drink? _____
Have you ever passed out from drinking? ___ Yes ___ No How often? _____
Have you ever blacked out from drinking? ___ Yes ___ No How often? _____
Have you ever had the "shakes"? ___Yes ___ No How often? _____
Have you ever felt you should cut down on your drinking/drug use? ___ Yes ___ No
Have people annoyed you by criticizing your drinking/drug use? ___ Yes ___ No
Have you ever felt bad or guilt about your drinking/drug use? ___ Yes ___ No
Have you ever drank/used drugs in the morning to steady your nerves or relieve a handover? ___ Yes ___ No
Do you use tobacco? ___ Yes ___ No If yes, how often? _____

Other Drugs:

Drug	Ever Used	Age at 1st use	Time since last use	Approx. use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

_____

_____

_____

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Primary Care

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements
so that we may proceed with the care and treatment ordered by your physician.

1. CONSENT TO SERVICES: I understand that a patient's care is directed by his/her attending physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician (s).

2. FINANCIAL AGREEMENT: I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the physician/clinic in accordance with the charges listed on the claim and, if applicable, the physician/clinic's charity care and discounted payment policies and state and federal law. The physician/clinic may provide, upon my request, a reasonable estimated of charges for items and services based on the charge fee schedule. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the physician/clinic may bill my insurance company or health benefit plan but is not required to do so. I agree and understand, except where prohibited by law, the financial responsibility for the services rendered belong to me, the undersigned. I further understand that the obligation to pay the physician/clinic may not be deferred for any reason, including pending legal actions against other parties to recover medical cost. The physician/clinic shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including radiologist, pathologist, emergency physician, anesthesiology, hospitalist, and others if applicable will bill separately for their services. For your convenience we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.

3. PHYSICIAN/CLINIC TO ACT AS AGENT: I irrevocable assign and transfer to the physician/clinic all rights, benefits, and any other interest in connection with any insurance plan health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the physician/clinic of all insurance and health plan benefits payable for any services rendered. I agree that the insurers or plans payment to the physician/clinic shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal lay. I agree to cooperate with and take all steps reasonably requested by this physician/clinic to perfect, confirm, or validate this assignment. I also hereby authorize the physician/clinic, or its designee, to act on my half in any dispute with a managed care organization government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursing such appeals.

4. CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the clinic/physician to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, test messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

5. CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contact, unless I notify to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at the email address from the clinic/physician.

6. ELECTION TO ELETRONICALLY TRANSMIT MEDICAL INFORMAITON AT DISCHARGE: I authorize physician or clinic to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care providers(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information

disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

7. ELECION TO PARTICIPATE IN HEALTH INFORMAITON EXCHANGE(S): I hereby authorize physician/clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which physician/clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and, in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which physician/clinic participates may be found in the Notice of Privacy Practices, which is available upon request, and this list may be updated from time to time if and when physician/clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

1. PATIENT APPOINTMENT AND CONDUCT: I understand that unless cancelled 24 hours in advance, you are expected to appear on time for your appointment. Three (3) or more missed appointments in a 12-month period will result in a warning letter and five (5) or more missed appointments in a 12-month period may result in dismissal from the practice upon provider review and patients will be asked to seek treatment elsewhere. I am expected to be respectful to clinic staff and other patients. This includes use of appropriate language and heavier. Patients who use profane language, cause physical harm, or threaten to cause harm will be dismissed from the practice.
2.
3. HIPAA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS: I understand and have been provided with a Notice of Privacy Practices and patient rights that provides a more complete description of my health care information uses and disclosures.

4. AUTHORIZATION TO DOWNLOAD PHARMACY INFORMATION: I understand and authorize physician/clinic to download my last 13 months of prescription history.

5. CONSENT TO PHOTOGRAPH: I consent to photographs, videos or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.

6. ADVANCE DIRECTIVE ACKNOWLEDGEMENT: I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. U understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

☐ Yes, I have executed an Advance Directive
☐ No, I have not executed an Advance Directive.

My signature indicates that I have read and fully understand this Patient Consent and Financial Agreement and have been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

_____ _____
Signature of Patient or Legal Representative Date/Time

_____
Relationship to Patient

_____ _____

Signature of Witness Date/Time