Patient Registration

Patient Name _____ Patient's Social Security Number _____

Street Address _____ City _____ Zip _____

Date of Birth _____ Marital Status S M W SEP D Sex M F

Telephone #: Home _____ Work _____ Cell _____

Email _____ Race _____ Ethnicity _____

Name on Insurance Card (if not you): _____ Date of Birth _____

Address _____ Phone: _____

Pharmacy Name _____ Street: _____ City: _____

Mail Order Pharmacy _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact _____ Tel# _____ Relationship _____

Referred By _____ Name of Primary Care Doctor _____

Employer Name _____ Occupation _____

Medications List

Medication Name (Include over the counter medication)	Strength / Dose (mg)	Number of pills per dose	Number of times Per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

Past Medical History

Diabetes	____ Yes	___ No		Emphysema / COPD	____ Yes	___ No
High Blood Pressure	____ Yes	___ No		Pneumonia	____ Yes	___ No
Stroke	____ Yes	___ No		Depression / Bipolar	____ Yes	___ No
Heart Disease / Heart Attack	____ Yes	___ No		Mental Illness	____ Yes	___ No
Kidney Stones	____ Yes	___ No		Dementia (Alzheimer's etc.)	____ Yes	___ No
Thyroid Disease	____ Yes	___ No		Ulcers	____ Yes	___ No
Seizures	____ Yes	___ No		Liver Disease	____ Yes	___ No
Bleeding Disorder	____ Yes	___ No		High Cholesterol	____ Yes	___ No
Sexually Transmitted Disease	____ Yes	___ No		Irritable Bowel Syndrome	____ Yes	___ No
Tuberculosis	____ Yes	___ No		Glaucoma	____ Yes	___ No
Rheumatic Fever	____ Yes	___ No		Osteoporosis	____ Yes	___ No
Asthma	____ Yes	___ No		Cancer	____ Yes	___ No
Anxiety	____ Yes	___ No		▪ Cancer Type		
Diabetes If yes, date of last: Eye exam _____ Diabetic Retinopathy of Laser Foot exam _____ History of foot ulcers Hand or Feet Numbness	____ Yes ____ Yes ____ Yes ____ Yes	___ No ___ No ___ No ___ No		Other _____ _____ _____ _____ _____ _____		

Allergies

Drug/Non-Drug Allergy	Allergic Reaction

Surgical History/Hospitalizations

Previous Hospitalizations and Surgeries	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

	Living	Age	Deceased	Age at Death	Medical History (Ex. Diabetes, Stroke, Heart Attack)
Father	☐		☐		
Mother	☐		☐		
Siblings	☐		☐		
_____	☐		☐		
Children	☐ Sons How many_____		☐ Daughters How many_____		

Patient Social History

Use of Alcohol:	___Never ___Rarely ___Moderate ___Daily
Use of Drugs:	___Never ___Yes, Type/Frequency_____
Use of Tobacco:	___Never ___Previously, but quit When?_____ ___Current Packs/Day_____
Exercise:	___No ___Yes, Type/Frequency_____
Caffeine:	___No ___Yes, Type/Frequency_____
Advanced Directive:	___No ___Yes (please provide us with a copy)
Power of Attorney (POA):	___No ___Yes (please provide us with a copy)

Patient Consent

Consent to Treat & Financial Authorization

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order
I request that payments of authorized benefits from Medicare/Insurance Company be made directly to my provider
I authorize my provider to release any medical information about me to HCFA/my insurance and its agents, any information needed to determine these benefits or the benefits payable to related services. I authorize the use of this authorization for any of my insurance submissions I understand that I am responsible for any amount not covered by my insurance company(s). I certify the information that I have reported with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of its original. This authorization may be retrieved by either me or my insurance company at any time in writing

Patient Signature _____ Date _____ Parent Signature _____ Date _____

HIPAA Consent

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please Review it carefully.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policies.

We may use or disclose your protected health information for purpose of treatment, payment or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization for any other use or disclosure. You may revoke your consent or authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization is in effect.

We will provide access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in cases of work-related illness or injury), courts and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may want a friend or family member to discuss care with a physician(s), or staff member, take messages, and pick up prescriptions or other medically related communications.

- Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

  Name: _____ Phone: _____

You may also identify a friend or family member to whom we are specifically restricted from releasing medical information from:

Name: _____ Phone _____

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S. Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: 313-908-9374 This notice is effective: 2/29/12

The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.

_____ _____
Signature Date

Permission to Communicate my Health Information Electronically

Our office is pleased to inform that we now participate in a health information exchange. As you may be aware, health information exchanges allow for electronic communication and access to your electronic medical record. This electronic access, in turn, supports opportunities for improved continuity of care by physicians and other healthcare personnel who are involved in your care. Most important is that health information exchanges create a means by which healthcare data may be accessed in a shorter period than has been traditionally the case with paper records.

Participation in the health information exchange could give your healthcare provider access to critical information such as your home address, past medical history, surgical history, hospitalizations, family history, social history, vital signs, immunizations, allergies, chronic medical conditions, previous and current medications, laboratory and radiology test results. Of course, your privacy protections through HIPAA would remain and providers will be expected to access information consistent with these rules.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN THE EXCHANGE AS PROVIDED FOR BELOW.

______ **YES**, I want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have been informed about information that will be communicated and have had the opportunity to ask any questions that about this decision. I understand that I have the right to change my mind and can withdraw permission by updating this form by checking the NO section and entering a revised date. If I withdraw permission any information in my electronic medication record will not be accessible by the health information exchange. At that point my doctor will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

_____ **NO**, I do not (or no longer) want to participate to communicate my health information with healthcare professionals involved in my healthcare through the health information exchange. I have had the opportunity to ask any questions about this decision. I understand that my information will continue to be stored in my electronic medical record but will not be accessible by the health information exchange. I understand that by not participating it may be more difficult for physicians and other healthcare providers to coordinate my care, especially in an emergency situation or when my physician is not available. My physician will still be able to communicate my information by the standard methods of telephone, fax, U.S. mail and encrypted email.

____

Print First Name, Last Name, DOB

____ ________________________

Signature of Patient or Representative Date

_ _

Rx History Consent

I give permission for my provider to access my pharmacy benefits data electronically through RxHub. This consent will enable my provider to: determine the pharmacy benefits and drug co pays for a patient's health plan, check whether a prescribed medication is covered (in formulary) under a patient's plan, display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, download a historic list of all medications prescribed for a patient by any provider.

Patient Signature _____________________________ Date ________

Parent Signature ______________________________ Date __________