WOODLAND HEIGHTS CARDIOTHORACIC ASSOCIATES

PATIENT REGISTRATION FORM

SOCIAL SECURITY #	PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORKPHONE	CELLPHONE	SEX ☐MALE ☐ FEMALE	DATE OF BIRTH
EMPLOYER		EMPLOYER ADDRESS		
EMPLOYER PHONE		EMAIL ADDRESS		
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED ☐ OTHER		

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

☐ CHECK IF SAME AS ABOVE / IF NOT, PLEASE COMPLETE BELOW

RELATIONSHIP TO PATIENT	GUARANTOR'S LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	SEX ☐MALE ☐ FEMALE	DATE OF BIRTH
SOCIAL SECURITY #	EMPLOYER		EMPLOYER PHONE	
EMPLOYER ADDRESS			EMAIL ADDRESS	

SPOUSE INFORMATION

☐ CHECK IF SAME AS ABOVE / IF NOT, PLEASE COMPLETE BELOW

FIRST NAME		LAST NAME		
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	DATE OF BIRTH	
SOCIAL SECURITY #	EMPLOYER		EMPLOYER PHONE	
EMPLOYER ADDRESS			EMAIL ADDRESS	

EMERGENCY CONTACT

☐ CHECK IF SAME AS PERSON RESPONSIBLE FOR PAYMENT / IF NOT, PLEASE COMPLETE BELOW:

NAME	HOME PHONE	CELL PHONE	WORK PHONE	RELATIONSHIP TO PATIENT

ADVANCED DIRECTIVES / LIVING WILL: ☐ YES ☐ NO

PATIENT MEDICAL HISTORY

PATIENT NAME_____M____F____DATE OF BIRTH_____

PRESENT MEDICAL PROBLEM_____

_____

_____

_____

LIST ALL CURRENT MEDICAL ILLNESSES SUCH AS HIGH BLOOD PRESSURE, HEART DISEASE, DIABETES, STROKE, PNEUMONIA, BLOOD DISEASES

_____

_____

_____

_____

LIST PREVIOUS SURGERIES & DATES

_____

_____

_____

_____

_____

SOCIAL HISTORY

DO YOU SMOKE OR USE ANY TOBACCO PRODUCTS?_____

_____

DO YOU DRINK ALCOHOL?_____

MARITAL STATUS_____

WHAT TYPE OF WORK DO YOU DO?_____

FAMILY HISTORY OF DISEASES

PARENTS _____

SIBLINGS_____

OTHERS_____

PATIENT NAME:_____DATE_____

DO YOU HAVE ANY SKIN LESIONS, RASHES, REDDNESS_____YES _____NO_____

FEVER _____YES _____NO _____SWEATS____YES ____NO_____

WEIGHT LOSS ____YES ____NO_____

FREQUENT THIRST ____YES _____NO _____

HEADACHES _____YES _____NO _____

BLACKOUT SPELLS _____YES _____NO _____

BLURRED VISION/LOSS OF VISON _____YES _____NO _____

DIZZY SPELLS _____YES _____NO _____

NUMBNESS OR TINGLING OF ARMS, HANDS, OR LEGS ____YES ____NO _____

HEARING LOSS ____YES _____NO;DENTURES _____YES _____NO; SINUS DRAINAGE ___YES ___NO

SHORTNESS OF BREATH ____YES ____NO _____

COUGH OR SPUTUM ____YES ____NO _____

BLOOD CLOTS IN LUNGS _____YES _____NO _____

CHEST PAIN OR INDIGESTION ___YES ___NO _____

SWELLING OF LEGS, ANKLES, OR FEET _____YES _____NO _____

DIFFICULTY SWALLOWING SOLID FOOD OR LIQUIDS ____YES ____NO _____

ANY HISTORY OF PEPTIC ULCER DISEASE OR STOMACH ULCERS ___YES ___NO _____

RECENT CHANGE IN BOWEL HABITS _____YES ____NO _____

BLOOD IN STOOL _____YES _____NO _____

FREQUENT URINATION AT NIGHT _____YES _____NO _____

PAIN OR DIFFICULTY WITH URINATION ____YES ____NO _____

ANY TYPE OF BLEEDING DISORDER _____YES _____NO _____

EASY BRUISING _____YES _____NO _____

ANEMIA or BLOOD DISEASES_____YES_____NO_____

LEG CRAMPS DURING EXERCISE ____YES ____NO _____

BLOOD CLOTS IN LEGS_____

LEG PAINS AT NIGHT _____YES _____NO _____

JOINT OR MUSCLE PAIN ____YES _____NO _____

WOODLAND HEIGHTS CARDIOTHORACIC ASSOCIATES

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

PRIVACY ACKNOWLEDGEMENT

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? ☐Yes ☐No
   If no, is there another number at which we may try to reach you? _____
2. May we mail to the address you provided information regarding your appointment or test results?
   ☐Yes ☐No If no, is there another address at which we may send you information?
   _____
3. Do you wish us to share health information regarding you with a family member or friend?
   ☐Yes ☐No If yes, please provide name of person(s). _____
4. May we contact you via e-mail with information about our practice, educational programs and general health information?
   ☐Yes ☐No If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

NOTE: To protect your information, we reserve the right to use professional judgment and discretion when communicating information/ test results which may be "sensitive" in nature.

I have received a copy of Woodland Heights Family Practice at Gaslight Group's "Notice of Privacy Practices for Protected Health Information."

REFERRALS FOR SERVICES

Welcome to the Woodland Heights Family Practice at Gaslight. In an effort to make treatment for our patients as enjoyable and timely as possible, out department has adopted the following policy regarding scheduling and cancelations. If you are up to **15 minutes** late, your physician may not be able to see you. Please understand that if you are treated, your treatment may be modified to accommodate other scheduled patients. If you are **30 minutes** late, you may need to reschedule your appointment for another time. Failure to keep **3** scheduled appointments without giving notice may result in your discharge from the physician. Failure to keep **5** scheduled appointments, even with advance notice, will result in your discharge from physician.

CONSENT TO TREAT

I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant, and nurse practitioner, and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HB\1, Hepatitis C virus or HC\1, and Human Immunodeficiency Virus or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statute, regulation or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

FINANCIAL AGREEMENT

Patient and/or guarantor is responsible for charges incurred. Any charges shall be based on the prevailing rate for the specific services rendered or items provided, that is in effect in the charge master on the date such services are rendered or items provided. It is a courtesy of our office to file your insurance; however you are responsible for your co-pay and/or percentage which the insurance company is not liable for on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, and you agree to be responsible for additional expenses incurred (if applicable including but not limited to, court costs and attorney fees) if legal action is necessary for collections.

By signing this form I am authorizing contact for purposes of financial matters and account collection through any telephone number provided. Patient and/or guarantor agrees to permit Woodland Heights Family Practice at Gaslight or its agents to review financial ratings and credit reports when necessary. I have read and fully understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to this medical practice. I also authorize the release of any information acquired in the course of my treatment to my insurance company or any third party obligated to pay all or part of my medical bill as needed to issue benefits.

To insure the accuracy of your information, photo identification is required. Without photo identification, we require your photograph. I certify that all identification information is true and correct. I understand that providing false identification is a crime and may be reported to local law enforcement.

CONSENT TO PHOTOGRAPH:

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that Woodland Heights Family Practice at Gaslight will retain ownership rights to these recordings or other images, but that I will be allowed to view them or obtain copies. I understand that these images will be stored in a secure manner to protect my privacy and that they will be kept for the time period required by law or Woodland Heights Family Practice at Gaslight's policy. Images that identify me will be released and/or used only upon written authorization from me or my legal representative.

MEDICARE AND MEDICAID INFORMATION

y that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I au: :e any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I further certify that I have provided any required information concerning any other liability for medical practice charges in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf.

I authorize Woodland Heights Family Practice at Gaslight to secure information from the Department of Human Services regarding my qualification for Medicaid.

BY SIGNING AND DATING THIS ATTACHED SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT.

Patient / Authorized Representative Signature _____ Date_____ Time._____

If Authorized Representative, relationship to Patient: _____

If person other than patient is responsible for payment:

Guarantor Signature _____ Date _____ Time _____

Witness Signature _____ Date _____ Time _____

Woodland Heights

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		