NEW PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____

Sex: F / M SS#: _____ Race: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Text: Y / N

Email: _____

Occupation: _____ Employer: _____

Work Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Guardian/Spouse Name: _____ DOB: _____

Employer: _____ Work Phone: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Family Medical Doctor: _____

IF THIS SECTION IS NOT COMPLETED AND WE DO NOT HAVE A COPY OF YOUR INSURANCE CARD, WE CANNOT FILE ON YOUR INSURANCE AND YOU WILL BE RESPONSIBLE FOR YOUR VISIT.

Primary Insurance Plan: _____

Name of Policy Holder: _____ DOB: _____

Policy Holder Address (if different from above) _____

City: _____ State: _____ Zip Code: _____

Policy Holder Employer: _____ Policy Holder SS#: _____

Secondary Plan (if applicable) _____

Name of Policy Holder: _____ DOB: _____

REASON FOR TODAY'S VISIT? _____

_____

_____

Authorization For Insurance

I certify that I (or dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST, AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO YOUR CHOICE HEALTHCARE, P.C. INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responisible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submission.

Patient's Signature: _____ Date: _____

Parent or Legal Representative Signature: _____ Date: _____

HEALTH HISTORY

Current Primary Care Provider: _____

_____ AIDS/HIV
_____ Alcoholism
_____ Allergies/Hay Fever
_____ Anemia
_____ Arthritis/Gout
_____ Asthma
_____ Bleeding Disorder
_____ Cancer
_____ Cataracts
_____ Chemical Dependency
_____ Chicken Pox
_____ Breast Lump
_____ Bulimia

_____ Diabetes
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Glaucoma
_____ Goiter/Thyroid
_____ Heart Disease
_____ Hepatitis
_____ Hernia
_____ Herniated Disc
_____ High Blood Pressure
_____ High Cholesterol
_____ Kidney Disease

_____ MRSA Exposure
_____ Migraines
_____ Mono
_____ Osteoporosis
_____ Pacemaker
_____ Pinched Nerve
_____ Psychiatric Care
_____ Reflux/GERD
_____ Rheumatic Fever
_____ Scarlet Fever
_____ STD
_____ Stroke
_____ Ulcers

Family History:
(Parents, Siblings, Grandparents)
Please indicate, if applicable, who has had:

Heart Disease _____
High Blood Pressure _____
Stroke _____
Diabetes _____
Kidney Disease _____
Liver Disease _____
Psychiatric _____
Cancer(&type) _____
_____
OTHER _____

Are you currently under Pain Management or any medical care? _____ Yes _____ No

If yes, please explain. _____

_____

_____

Please list any allergies _____

Please list any surgeries, including dates: _____

_____

_____

Daily/Weekly intake of the following:
Caffeine _____ cups/day Alcohol _____ drinks/week Tobacco _____ packs/day

If not currently, did you ever use tobacco? _____ # of years quit? _____
Do you live alone? _____ Or with others? _____
General stress level? Low _____ Med _____ High _____
Are you hard of hearing or deaf in one or both ears? _____
Are you legally blind in one eye? _____

I certify that the above questions were answered accurately. I understand that providing incorrect information or withholding information can be dangerous to my health.

Patient Signature _____ Date _____

Parent/Legal Representative Signature _____

CHRONIC MEDICATION LIST

Name: _____

Date of birth: _____

Pharmacy: _____

Allergies: _____

_____

Medication	Dosage	Frequency

(WOMEN) OB/GYN History

Date of Last Pap Smear: _____ ☐ Abnormal

Date of Last Mammogram: _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____

Births: _____ Miscarriages: _____ C-Sections: _____

Current Birth Control Method: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
- ☐ Interested in being screened for STD's

CONSENT TO CARE

I, _____, authorize the healthcare providers of Your Choice Healthcare, P.C. to administer treatment as deemed necessary for care of the above named patient. This pertains to today's visit and any future visits involving treatment by the healthcare providers of YCHC, P.C. I certify that I am the patient or the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results tht may be obtained from the treatment. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the provider.

I have read and understand the foregoing:

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Representative's Signature (if required) Date

_____

Relationship to patient

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices for Your Choice Healthcare, P.C. regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the clinic and my respective rights contained therein.

I also understand that the Notice is furnished to me is subject to change at any time. I am aware that I may obtain a copy of this Notice at any time by contacting 478-559-3154, 820 Second Ave, Eastman, GA 31023.

My signature herein constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for Your Choice Healthcare, P.C.

_____ _____

Patient Signature Date

_____ _____

Patient's Legal Representative Date

_____

Relationship to patient

I, the patient, hereby authorize Your Choice Healthcare, P.C. to release my medical information (appointments, lab/x-ray resultss, diagnoses, treatments, medications, surgeries, etc.) via telephone or in-person to the following family members:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

****PLEASE NOTE: VALID PHOTO IDENTIFICATION WILL BE REQUIRED WHEN REQUESTING INFORMATION IN-PERSON.**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:
_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Your Choice Healthcare
Address: 820 2nd Ave
City, State, Zip: Eastman GA 31023
Fax: 478-559-3150 **Phone:** 478-559-3154

☐ **Please mail records.**
☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

_____ _____

Printed name of Authorized Representative

Relationship / Capacity to patient

_____

Address and telephone number of authorized representative