Patient Registration Form

Pauls Valley Family Healthcare APRN, FNP-BC LLC
34550 Airline Road • Pauls Valley, OK 73075
Phone: 405-207-9238 Fax: 405-207-9240
pvfamilyhealthcare@gmail.com

Patient Information:

First Name:	Last Name:	MI:	DOB:

SS#: / /	Sex: M / F	Employed: Yes / No	Occupation:

Home Address:	Mailing Address If Different:

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Other

Contact Information: Providing an email address gives you access to the patient portal, which includes: making payments, viewing medical records and requesting appointments.

E-Mail_____

Cell_____

Home Phone_____

Leave voice message? Yes No

Select preferred method of electronic communication:
☐ Text ☐ Email

Select preferred method of written communication:
☐ Email ☐ Mail

Ethnicity:
- ☐ Patient Decline
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ White
- ☐ Black / African American
- ☐ American Indian / Alaskan Native
- ☐ Native Hawaiian / Pacific Islander
- ☐ Asian
- ☐ Other Ethnicity_____

Emergency Contact:

Name:	Phone #:	Relationship:

Address:	City, State, Zip:

Access to your Patient Portal: NO YES (Requires e-mail)	Mother Maiden Name:

Responsible Party: ***NO MINORS*** **can be listed as a responsible party**

Guardian present and signing paperwork, all adults over 18 years of age will be listed as **SELF** for responsible party

Name:	Employer:	DOB:

Mailing Address:	City, State Zip:	Phone: SS#:

INSURANCE INFORMATION

Primary Insurance - Please provide card at check-in

Name of Insurance	Insurance ID Number:	Group Number:

Policy Holder Information:

Name (Last, First, MI):	Relationship to Patient:	Phone #:

Subscriber SS#: / /	Sex: M / F	DOB:	Employer:

Secondary Insurance:

Name & Phone Number of Insurance: Name of Policy Holder:	Insurance ID Number: Group:

Any Additional Insurance:

Name & Phone Number of Insurance: Name of Policy Holder:	Insurance ID Number: Group:

All charges are due at the time of service. All service rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. I understand that I am responsible for all charges including deductible, co-pay's, co-insurance, etc. not covered by insurance plan. Therefore I hereby authorize Pauls Valley Family Healthcare ARNP, FNP-BC LLC to furnish any information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS. I assign Paula Guinnip all payments for medical services rendered to myself.

_____ _____

Signature Date

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

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_____

Pharmacy Location Phone Number

Patient Medication List

(including over the counter drugs and vitamins)

Do you give our office consent to import from your pharmacy listed? ☐ Yes ☐ No

Drug Name	Dosage	Frequency	Prescriber

********** Please list ANY drug allergies and symptoms / reactions:**

_____

_____

_____

_____

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

MEDICAL HISTORY QUESTIONNAIRE

Personal History	Yes	No
Allergy (Hay Fever)		
Anemia		
Anxiety		
Arthritis (Rheumatoid)		
Arthritis (Osteoarthritis)		
Asthma		
Bladder / Kidney Problems		
Blood Clot (leg)		
Blood Clot (lung)		
Blood Transfusion		
Cancer - Type		
Cataracts		
Colon Polyp		
Coronary Artery		
Depression		
Diabetes - Type		
Diverticulosis		
Emphysema (COPD)		
Gallbladder Disease		
Gastroesophageal Reflux (Heartburn/GERD)		
Glaucoma		
Gout		
Heart Attack		
Hepatitis - Type		
High Blood Pressure		
High Cholesterol		
Irritable Bowel Syndrome		
Kidney Disease / Failure		
Kidney Stones		
Liver Disease		
Migraine Headaches		
Osteoporosis		
Pneumonia		
Prostate (enlargement)		
Prostate (nodules)		
Seizure / Epilepsy		
Skin Condition (Eczema)		
Skin Condition (Psoriasis)		
Skin Condition (Abnormal Moles)		
Sleep Apnea		
Stomach Ulcer		
Stroke		
Thyroid (Nodule)		
Thyroid High (Overactive) / Hyperthyroidism		
Thyroid Low (Underactive) / Hypothyroidism		
Varicose Veins		
Spider Veins		

Family History

Adopted? ☐ Yes ☐ No

Diseases & Conditions	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
No significant history known								
Hypertension - High Blood Pressure								
Heart Attack, Angina (Coronary Artery Disease)								
Diabetes - Type								
Cancer, Breast								
Cancer, Colon								
Cancer, Prostate								
Cataracts								
Colon Polyp								
Coronary Artery								
Osteoporosis								
Depression								
Alcoholism / Drug abuse								
Alzheimer								
Asthma								
Autoimmune Disease								
Bleeding or Clotting Disorder								
Cancer, Lung								
Cancer, Other type								
Colon Polyp								
Diabetes Type 1 (childhood onset)								
Emphysema (COPD)								
Genetic Disorder (explain)								
Heart Disease (CHF)								
Heart Disease (Other)								
Hepatitis B or C								
Hip Fracture								
Hypothyroidism / Thyroid Disease								
Kidney Disease								
Kidney Stones								
Macular Degeneration								
Stroke								
Sudden Cardiac Death								
Other (list)								
Other (list)								

Social History, Do You: *(Please answer yes or no)*

Yes No Drink Caffeine

Estimate Caffeine Consumption

Yes No Smoke Cigarettes Packs Per Day? _____

Yes No Smoke Cigars

Yes No Chew Tobacco, Dip

Yes No Drink Alcohol Regularly

Estimate Alcohol Consumption _____

PATIENT NAME:_____ **DOB:**_____ **DATE:**_____

SURGICAL & PROCEDURE HISTORY

Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	No	Yes	Year	Comments
Abdominal Surgery				
Angiogram (heart)				
Angiogram (vascular)				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location in comments)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Cataract Surgery				
Colonoscopy				
Coronary Bypass				
Coronary Stent				
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)				
Gallbladder Removal				Circle: Laparoscopic (HX0271)
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck (Spine) Surgery				
Ovary Removal				Circle: Right Left Both
Pulmonary Function Test				
Sigmoidoscopy				
Sinus Surgery				
Stress Test (Stress Echo)				
Stress Test (Thallium/Perfusion)				
Stress Test (Treadmill)				
Tonsillectomy				
Tubal Ligation				
Vasectomy				
Other (List)				

☐ Check box if you have never had any medical procedures or surgeries.

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NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of patient: _____

Signature of patient: _____ Date: _____

Patient's Chart#:_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Relationship to patient: _____
(parent, guardian, etc.)

Signature of Personal Representative: _____

Date:_____

For Practice Use Only:

_____

_____

_____

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_____

_____

_____

_____ _____
Signature of Practice Representative Date

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Authorization for Use and Disclosure of Protected Health Information

You have the right to authorize another individual and a/or organization to provide or receive your protected health information. This form needs to be completed by answering all 5 questions, including your signature and date.

1: Please print your first and last name:_____

2: Provide the name of the person(s), organization(s) that you authorize to provide information for or about you. (Example: Name of your medical plan)

_____

3: Provide the name of the person(s) and their relationship - or the organization(s) that you authorize to receive information for or about you.

_____

4: Provide a purpose and specific description of the information that is to be used or disclosed. (Example: at the request of the individual, and to discuss all claim information for me)

Purpose:_____

Description:_____

5: Provide a date when this authorization will expire, indicate a date or an event that relates to you or to the purpose of the use/disclosure. (Example: the end of a specific year or no expiration date)

YOUR RIGHTS

This authorization is voluntary and I understand that I may revoke this authorization at any time prior to its expiration date by notifying **Pauls Valley Family Healthcare APRN, FNP-BC LLC**in writing, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that **Pauls Valley Family Healthcare APRN, FNP-BC LLC** took before it received the revocation.

I may inspect and copy the protected health information described on this form if I ask for it.

I am not required to sign this authorization to become eligible or to receive my health care benefits (enrollment, treatment or payment).

The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

Your signature or Your Representative's Signature

Signature **Date**

Printed Name **Relationship** **Legal Authority**

* (If this authorization is not signed by you, but is signed by your representative, 1) print their name, 2) their relationship to you and 3) their legal authority for status as representative (for example: Mary Smith, child, power of attorney)

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CLIENT/PATIENT MUTUAL AGREEMENT - FINANCIAL AGREEMENT

We are honored to care for you and your family. The purpose of this letter is to ensure that all of our patients have read over and understand our office policies. Please read over each policy and initial the preceding line indicating that you understand the policy, and sign and date at the end of the document. If you do not understand any of our policies, please feel free to ask our staff for assistance before signing the document.

PLEASE READ EACH STATEMENT AND SIGN AT THE BOTTOM OF THE PAGE

APPOINTMENTS

- Patients that arrive more than 15 minutes late to an appointment will be asked to reschedule the appointment time. Pauls Valley Family Healthcare asks for your cooperation so that we may remain on schedule as much as possible. We ask for a 24 hour notice for cancelled or rescheduled appointments.
- In consideration of other patients and providers, we ask that all phones be turned off or to be on silent mode.
- We require 48 hours notice to complete and approve a prescription refill. Please request your refill 48 hours prior to running out of medication.
- I verify that I have reviewed my insurance information listed and that it is correct. I understand that my provider may file a claim with my insurance company as a courtesy, but that it is my responsibility to follow up with my insurance company to ensure reimbursement. I understand that my physician cannot act as an intermediary between me and my insurance company to effect payment.
- Patients with an outstanding balance over ninety days will not be seen unless the illness is emergent or the patient enrolls and complies with a payment plan.
- I agree to pay my bill in full at the time services are provided for any type of visit.

Failure to show up for an appointment will result in a $25.00 missed appointment fee, which the patient is responsible for.

LAB RESULTS / MEDICAL RECORDS

- Please allow at least one week for lab test results. For specialty lab results, the wait may be longer than one week. Each lab test result is processed, faxed to us, and reviewed by the physician before results can be released. We will attempt to contact you by phone.
- As per HIPAA guidelines, we can not release any patient information to friends or family of the patient unless the individual is the parent or guardian of a minor (under 18 years of age) or is listed on the patients HIPAA consent form. Patients under 18 years of age must be accompanied by their parent or guardian in order for them to be seen.
- Our practice requires each patient or parent to provide a valid driver's license or other form of identification to be kept securely on file.
- I understand that medical records are the property of my provider; however, with sufficient advanced notice, upon my written request, I am entitled to a copy. Proper identification is required to release medical records.
- I understand and agree it is my responsibility to know if the provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
- I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any Medical service or visit, Preventative Exam of Physical, Lab Testing, X-Ray, EKG and any other screening service or diagnostic testing ordered by the provider or provider staff. I agree that it is not the responsibility of my physician to know if any diagnostic tests, labs, x-rays, EKGs are covered by my insurance; it is my responsibility to know this information.

PATIENT AGREEMENT: I HAVE READ AND FULLY UNDERSTAND THE CLIENT / PATIENT MUTUAL AGREEMENT AND AGREE TO ALL TERMS STATED ABOVE.

_____ - _____ _____

Patients Printed Name | Patient or Legal Guardians Signature | Date

Pauls Valley Family Healthcare APRN, FNP-BC LLC or Designee Signature _____

Scanned to file:_____