Chase Brexton Health Care
Because everyone's health matters.

PATIENT REGISTRATION FORM

General Information

Patient Legal Name: _____

Preferred Name: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ ☐ I do not have a permanent address

City/State/Zip Code: _____

Phone: _____ ☐ This phone receives texts Work Phone: _____

Email Address: _____

How should we contact you? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text ☐ Mail ☐ E-mail

Birth/Legal Sex: ☐ MALE ☐ FEMALE Social Security Number: _____

Current care provider: _____ Phone Number: _____

☐ I do not have a current care provider

In an effort to know more about the people we serve, we would appreciate the following information:

Preferred language (if other than English): _____

Race: ☐ Black/African American ☐ White/Caucasian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ More than one race ☐ Other ☐ Decline to State

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to State

Household Income: Total yearly income: _____ Number of people in household: _____

I am a Veteran ☐

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual ☐ Choose not to disclose ☐ Other: _____

Current Gender Identity: ☐ Male ☐ Female ☐ Gender Queer ☐ Other: _____ ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Choose not to disclose

Pronoun Preference: ☐ Male ☐ Female ☐ Other: _____

Employer: _____

Employer Address: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Special Needs such as a wheelchair, interpreter, or ambulance transportation, etc?: ☐ YES ☐ NO

If yes, please explain: _____

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PATIENT REGISTRATION FORM

Contacts for minors

PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OLD OR HAS A LEGAL GUARDIAN

Parent/Legal Guardian #1 Name: _____Phone #1:_____

Parent/Legal Guardian #2 Name: _____Phone #2:_____

Address if different than patient: _____

_____

Insurance and ID

Please have your ID and insurance card ready.

If patient is a minor, please present a copy of the birth certificate or other ID.

Ask for a sliding fee scale application if interested. This may lower charges for patients making less than 200% Federal Poverty Level (around $25,000 for one person/$50,000 for four)

How did you hear about us?

☐ Billboard	☐ Health Fair/Educational Event	☐ TV
☐ Bus Ad	☐ Newspaper Ad	☐ Website
☐ Community Agency/Church/School	☐ Online/Social Media	☐ Other
☐ Family/Friend	☐ Radio	

I certify that the information contained herein is accurate. If any information changes, I will notify Chase Brexton Health Care.

Patient Signature (if over 18): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

Office Use Only

____Responsible Provider verified/updated
____Home Location verified/updated
____Insurance information verified/updated
____Patient Alert Notes updated

Reviewed/entered into CPS by: _____ Date: _____

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PATIENT MEDICAL HISTORY FORM

Patient Legal Name: _____ Date of Birth: _____

Preferred Name: _____

Please complete this entire form to help us provide the best care possible. This information is for your health care provider only and will be kept confidential.

1. Personal Medical History

Medical Problems (high blood pressure, diabetes, asthma, etc.)

_____ _____ _____

_____ _____ _____

Psychiatric Problems (depression, anxiety, bipolar disorder, etc.)

_____ _____ _____

Hospitalizations/Surgeries

_____ Date _____

_____ Date _____

_____ Date _____

Medications (include herbal, vitamins, and supplements)

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

_____ _____ _____

2. Family Medical History

Has anyone in your family had any of the following medical problems? (circle all that apply)

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Kidney Disease/Dialysis
- ☐ Asthma
- ☐ Migraine Headaches
- ☐ Breast Cancer
- ☐ Colon/Intestine/Anal Cancer
- ☐ Other Cancer(s) (Type: _____)

Please fill in the details below:

	Living or Deceased	Current Age/Age at Death	Medical Problems
Mother			
Father			
Sibling			
Sibling			
Grandparent			
Grandparent			
Grandparent			
Grandparent			

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PATIENT MEDICAL HISTORY FORM

Patient Legal Name: _____ Date of Birth: _____

3. Preventive Care – When was your last…

	Date	Normal/Abnormal		Date
Mammogram	_____	_____	Flu Shot	_____
Pap Smear	_____	_____	Pneumonia Shot	_____
Colonoscopy	_____	_____	Tetanus Shot	_____
HIV Test	_____	_____	Shingles Vaccine	_____
Cholesterol Test	_____	_____	HPV/Gardasil Vaccine	_____
Eye Check-Up	_____	_____	Hepatitis Vaccine	_____

Please make sure to complete a Release of Information (ROI) for the offices/providers that have these records.

4. Social History

Do you smoke? ☐ YES ☐ NO If you quit, when was that? _____

How much alcohol do you drink and how often? _____

Do you use drug? ☐ YES ☐ NO If you quit, when was that? _____

If you have ever used drugs, please list what types and how often: _____

_____

Do you exercise? ☐ YES ☐ NO If yes, what do you do and how often? _____

_____

Who do you live with? _____

Are you working? ☐ YES ☐ NO Occupation: _____

Highest level of education:_____

Have you ever been abused? ☐ YES ☐ NO _____

_____

Do you have a: ☐ Living Will ☐ Medical Advanced Directive ☐ Psychiatric Advanced Directive

5. Sexual History

How many sexual partners have you had: this month _____ this year _____ in your lifetime_____

What is your sexual orientation? ☐ Straight/Heterosexual ☐ Lesbian/Gay/Homosexual ☐ Bisexual

☐ Other: _____

My sexual partners are: ☐ Male ☐ Female ☐ Both

Do you use condoms? ☐ Always ☐ Sometimes ☐ Never

If you or your partner use birth control, what kind? _____

Have you ever had an STD (sexually transmitted disease? ☐ YES ☐ NO

If yes, what kind? _____

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PATIENT ACKNOWLEDGEMENT FORM

Patient's Financial Responsibility and Permission to Release Medical Billing Data Related to a Claim

I hereby accept financial responsibility to pay Chase Brexton all amounts not covered by my health plan, including amounts for copayments, coinsurance, fee scale payments, deductibles, non-covered services and services for which I have not received a proper authorization or a referral. In addition, I accept financial responsibility for any health care benefits that are denied because I am not eligible to receive those benefits at the time of service.

I understand that Chase Brexton accepts payment by cash, credit card, money order or check. Payment is generally required for all services at the time the services are rendered, although Chase Brexton reserves the right to later send you an invoice for health benefits that may be denied by your health plan.

I authorize my health plan to make payment to Chase Brexton for services rendered. I also authorize Chase Brexton to use and disclose my health information as necessary to obtain payment. I understand that Chase Brexton will hold me financially responsible if I choose not to have my health plan cover a service.

If my health plan is subject to ERISA, I authorize Chase Brexton to act on my behalf to obtain payment for benefits. I also authorize Chase Brexton to appeal any denial of services or benefits by any health plan on my behalf. If my account is sent to a collection agency for non-payment, I agree to pay all reasonable fees that are charged to collect the outstanding amount that is due to Chase Brexton, including reasonable attorney's fees, interest and court costs.

General Consent to Treatment

I, or my legal representative on my behalf, agree to have Chase Brexton's health care practitioners provide evaluation and treatment for my condition, injury or illness.

Acknowledgement

By signing below, I acknowledge that I have carefully reviewed this form, have had the opportunity to ask questions, and voluntarily agree to its provisions.

I have also received the Patient Handbook, which contains the

- **Notice of Privacy Practices,**
- **Patient Rights and Responsibilities, and**
- **How to communicate feedback (compliments, complaints, and grievances.)**

Patient Legal Name or Legal Representative (printed):_____DOB:_____

Patient Preferred Name: _____

Signature of Patient or Legal Representative:_____Date:_____

* A copy of this Acknowledgement is available upon request.