Chase Brexton Health Care

Because everyone's health matters.

PATIENT REGISTRATION FORM

General Information

Patient Legal Name: ____

Name preference (How would you like to be addressed?): ____________________ 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
☐ Bus Ad
☐ Community Agency/Church/School
☐ Family/Friend
☐ Health Fair/Educational Event
☐ Newspaper Ad
☐ Online/Social Media
☐ Radio
☐ TV
☐ Website
☐ Other

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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PEDIATRIC PATIENT MEDICAL HISTORY FORM

Patient Legal Name: ____ Date of Birth: _________________

Preferred Name: ____

1. Birth History

Any pregnancy complications? ☐ NO ☐ YES If yes, explain: _____________________________________

Route of Delivery: ☐ Vaginal ☐ C-Section (Reason: ____)

Birth Weight: ________ lbs _________ oz

Any complications after birth? ☐ NO ☐ YES If yes, explain:______________________________________

2. Personal Medical History

Medications (include herbal, vitamins, and supplements)

Name	Dosage	Name	Dosage
____________________	__________________	___________________	________________
____________________	__________________	___________________	________________

Allergies

_____________________ ____________________ _____________________ __________________

Hospitalizations/Surgeries

____ Date ____________________

____ Date ____________________

Does your child have exposure to second-hand smoke? ☐ YES ☐ NO

Does your child get regular exercise? ☐ YES ☐ NO

Does your child spend frequent time in a home built before 1978? ☐ YES ☐ NO

Does your child attend day/childcare outside the home? ☐ YES ☐ NO

Medical Problems (check all that apply)

☐ Allergies	☐ Asthma	☐ Diabetes	☐ Growth Problems
☐ Obesity	☐ Acid Reflux (GERD)	☐ Eczema	☐ High Blood Pressure
☐ Ulcers	☐ Acne	☐ Headaches	☐ High Cholesterol
☐ Bedwetting	☐ Ear Infections	☐ Constipation	☐ Behavioral Problems
☐ ADD/ADHD	☐ Anxiety	☐ School Problems	☐ Depression
☐ Developmental Delay	☐ Cancer(s): _________________________________		

☐ Other: ____

Are there other medical concerns we should know about? ____

____

____

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PEDIATRIC PATIENT MEDICAL HISTORY FORM (Page 2)

Patient Legal Name: ____ Date of Birth: _________________

2. Family Medical History

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

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Kidney Disease/Dialysis
- ☐ Asthma
- ☐ Migraine Headaches
- ☐ Allergies
- ☐ Anemia (low blood count)
- ☐ Thyroid Disorder
- ☐ Anxiety/Neurologic Disorder
- ☐ Obesity
- ☐ 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			

3. Preventive Health

When was your child's last check-up? ____

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

Are immunizations up to date? ☐ NO ☐ YES ☐ UNSURE ***Please provide an updated immunization record**

Preferred Pharmacy: ____

Phone Number: ____

We must have the parent/guardian's permission to treat a child for each visit if someone other than the parent/guardian brings the child (ie. grandparent, aunt, uncle, friend, etc). If someone other than the parent/guardian may be bringing the child to an appointment, please ask for a <u>Designation for Another Person to Consent to Care</u> form.

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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 (printed):____DOB:_____________

Name preference (How would you like to be addressed?): ____

Signature of Patient or Legal Representative:____Date:________________

* A copy of this Acknowledgement is available upon request.