



1463 E McAndrews Rd Suite B
Medford, OR 97504
Phone: (541) 414-0481
Fax: (541) 414-0482

Patient Registration (Please print clearly)

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Gender: Male ___ Female ___

SS#: _____ Pharmacy & Location: _____

Race:

- American Indian or Alaska Native Asian African American
 Native Hawaiian/Other Pacific Islander White Decline to answer

Ethnicity:

- Hispanic or Latino Not Hispanic or Latino Decline to answer

Marital Status:

- Single Married Divorced

Driver's License #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Primary Phone: Home Work Cell Appt. Reminders OK? Yes No

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____ Occupation: _____

If patient is a minor:

Mother: _____ DOB: _____ Phone: _____

Father: _____ DOB: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Advanced Care Health Systems to provide my insurance companies with all information necessary to process insurance claims and assign payments to Advanced Care Health Systems all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: _____ Date: _____



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Health History

Name _____ Date of birth _____

Medical History (circle below if you have had any of the following):

- | | | | | |
|---------------------|---------------------|------------------|--------------|--------------------------|
| Allergies/Hay Fever | Artery Blockage | Fatigue | Anemia | DVT |
| Glaucoma | High Blood Pressure | Fibromyalgia | HIV/AIDS | Anxiety |
| Hearing Loss | High Cholesterol | Thyroid Problems | Arthritis | Bipolar Disorder |
| Rhinitis | Palpitations | Diverticulitis | Back Pain | Depression |
| Visual Loss | Vascular Disease | Hepatitis | Sciatic Pain | Anxiety |
| Breast Lump | Stroke | Hernia | Joint Pain | Asthma |
| Breast Cancer | Eczema | Spastic Colon | Epilepsy | COPD/Emphysema |
| Arrhythmia | Skin Cancer | Ulcer | Meningitis | Pneumonia |
| Heart Attack | Skin Problems | Reflux | Migraine | Tuberculosis |
| Heart Murmur | Diabetes | Abnormal Periods | Edema | Bladder/Kidney Infection |

Other problems not listed _____

Have you had cancer (list type and treatment) _____

Have you had any of the tests below:

	Date	Reason	Where was the test done?
Heart Test	_____	_____	_____
Ultrasound	_____	_____	_____
CT Scan	_____	_____	_____
MRI	_____	_____	_____
Bone Density	_____	_____	_____
Colonoscopy	_____	_____	_____
Sigmoidoscopy	_____	_____	_____
Mammogram	_____	_____	_____

Past surgical history (include date or age you had the surgery):

Date	Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications, vitamins, supplements, over the counter medications (with dosage):

I don't take medication

Name of Medication	Dosage	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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List all allergies (medications, environmental, and food):

Medication	Reaction	Environmental or food	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccinations (date of last):

Tetanus/Tdap _____ Flu _____ Pneumonia _____ Shingles _____

Family medical history:

	Medical problems	Living or deceased	Age at death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Other	_____	_____	_____

Social history:

Present occupation _____ Past occupation _____ Highest level of education _____
 Have you served in the military _____ Places you have lived _____
 Religious preference _____ Is faith important to your health _____
 Do you consume alcohol _____ Last drink _____
 How many drinks a week _____
 Do you or have you use(d) recreational drugs _____ What drugs _____
 Do you or have you smoke(d) _____ Age started _____ Age quit _____ Packs per day _____
 Do you exercise _____ How often _____ What type of exercise _____

Do you have any of the following symptoms (circle all that apply if you have any of the following):

- | | | | | |
|----------------|----------------------|-------------------------|--------------------|----------------------|
| Weight Gain | Ringling in Ears | Short of Breath | Bloody Urine | Muscle Pain/Weakness |
| Weight Loss | Deafness | Poor Appetite | Frequent Urination | Memory Problems |
| Night Sweats | Sinus Problems | Abdominal Pain | Painful Urination | Back Pain |
| Fever/Chills | Cough | Nausea/Vomiting | Sexual Problems | Joint Pain/Swelling |
| Headaches | Irregular Heart Beat | Diarrhea | Rash | Change in Energy |
| Visual Changes | Chest Pain | Constipation | Skin Changes | Depression |
| Dizzy/Vertigo | Palpitations | Changes in Bowel Habits | Fainting | Anxiety |
| Earache | Swelling | Heartburn | Seizures | Trouble Sleeping |
| Allergies | Wheezing | Impotence | Numbness | Thoughts of Suicide |

Women:

Number of pregnancies _____ Deliveries _____ Miscarriages _____ Abortions _____ Ectopic pregnancies _____
 Age menses started _____ Age menses stopped _____ Last period _____ Last PAP smear _____
 Do you have:
 Painful periods _____ Pain with sex _____ Irregular periods _____ Problems getting pregnant _____
 Are you sexually active _____ Using any type of birth control _____
 What birth control have you used in the past _____



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Consent to Release Protected Health Information

Patient Name _____ Date of Birth _____

Consent

I request Advanced Care Health Systems to release protected healthcare information to:

Name _____

Relationship to Patient _____ Phone # _____

Name _____

Relationship to Patient _____ Phone # _____

Name _____

Relationship to Patient _____ Phone # _____

This request and authorization applies to: (please check below)

All healthcare information (Medical and Billing)

Healthcare information relating to the following treatment, condition or dates:

Other _____

I understand that this designation applies only to Advanced Care Health Systems.

Patient Signature _____ Date Signed _____

Revocation/Termination

I request to revoke/terminate the designation made above.

Patient Signature _____ Date Signed _____



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Authorization to Use and Disclose Health Information

I hereby authorize (previous healthcare provider):

To disclose to:

Name of disclosing party

Name of Recipient

Address

Address

City, State Zip

City, State Zip

Phone

Fax

Phone

Fax

Records and information pertaining to:

Patient name (list other names used)

SS#

Date of Birth

Address

Phone number

For the purpose of: _____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial to specify which type of information is to be disclosed, and then sign and date.

- Medical information _____ (initials) Psychiatric information _____ (initials)
- Drug/Alcohol Information _____ (initials) Results of HIV Test _____ (initials)
- Genetic Records _____ (initials)

Signature: _____ Date: _____



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Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ (print patient name), acknowledge and agree that I have received a copy of Advanced Care Health Systems Notice of Privacy Practices.

Patient signature _____ Date _____

Patient legal representative signature _____ Date _____

Print name of legal representative _____

Relationship to patient _____

FOR CLINIC USE ONLY

Advanced Care Health Systems made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices.

_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____
_____	Date _____



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Appointment Cancellation and No-Show Policy

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** will be considered a NO SHOW.
- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** a second time will be charged a **\$50.00** fee.
- If a third No Show or cancellation/reschedule with no **24-hour notice** should occur the patient may be **dismissed** from our practice.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- If you are late for an appointment you may have to reschedule your appointment. Please be 15 minutes early for your appointment so we can take care of administration tasks.
- As a courtesy, when time allows, we make reminder calls for appointments.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office immediately. Our provider will be notified and we might be able to waive the No Show fee. You can leave a message on our answering machine 24 hours a day, 7 days a week.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Patient/Parent/Legal Guardian)

Relationship to Patient (self, parent, etc.)

Print Name (Patient/Parent/Legal Guardian)

Date