



# PATIENT REGISTRATION FORM

Date: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON BEING SEEN TODAY.**

Patient's Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Race: \_\_\_\_\_ White/Caucasian \_\_\_\_\_ Black/African American \_\_\_\_\_ Asian \_\_\_\_\_ Decline \_\_\_\_\_ Other(explain): \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Non-Hispanic/Non- Latino \_\_\_\_\_ Hispanic/Latino \_\_\_\_\_ Unknown \_\_\_\_\_ Decline

Preferred Language: \_\_\_\_\_ English \_\_\_\_\_ Spanish \_\_\_\_\_ Other: \_\_\_\_\_

Patient's Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Preferred Contact Information:

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING INFORMATION FOR RELEASE OF MEDICAL INFORMATION.**

I do not authorize any information to be released to anyone other than myself.

- Do we have your permission to leave you messages on a voicemail? Yes / No
- Do we have your permission to discuss your medical condition with any member of your household? Yes / No.

I hereby authorize my protected health information (ex: appointment information, results, medications) to be discussed with the following individuals. Name and Relationship:

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

3) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

4) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_



## PATIENT REGISTRATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE PERSON WHO IS RESPONSIBLE FOR THE PATIENT.

Responsible Person's Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_ Marital Status: \_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION FOR THE PATIENT.

Primary Insurance Carrier: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Subscriber's ID: \_\_\_\_\_ Group#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to Pt: \_\_\_\_\_

If patient is a minor, please have the legal guardian sign. Your signature acts as a consent to be treated.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PATIENT PORTAL REGISTRATION

The patient portal is available through Habersham Medical Center's website. Through this portal the patient is able to view medication lists and discharge information, test results, message providers, as well as schedule appointments. If you are interested in signing up for the patient portal, please complete the form below.

Patient's Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last four of Social Security: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please sign below authorizing temporary patient portal information to be sent to the above email address listed. ID must be presented at time of request. We cannot look up copies of ID that may be on file.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## SUMMARY OF NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We have a duty to protect the confidentiality of medical information about you. We are required to provide you with a Notice of Privacy Practices explaining ways we may use and disclose your medical information. The Notice also describes your legal rights and our obligations regarding the use and disclosure of your medical information.

Parties following the Notice: The Notice will be followed by the Hospital and its affiliates, together with their health care professionals, staff, and volunteers; members of the Hospital Medical Staff and those participating in managed care networks with the Hospital; and other legal entities that provide services to the Hospital.

How We May Use and Disclose Medical Information About You: We may use or disclose identifiable health information about you for many reasons, including:

- Treatment As required by law
- Payment Lawsuits and disputes
- Auditing Public health purposes
- Research Activities of our affiliates
- Organ Donation Law enforcement purposes
- Fundraising To military command authorities
- Health Care Operations National security and protective services
- Appointment Reminders To avert a serious and protective services
- Workers' Compensation Too coroners, medical examiners, and funeral directors
- Health oversight activities Activities of managed care networks in which we participate

In general, other uses and disclosures of your medical information will require your written authorization. We may use or disclose certain limited information about you, unless you object or request a limitation of the disclosure, for: Hospital Directories- Individuals involved in your care or payment.

Your Privacy Rights: You have the following rights with respect to your health information:

- The right to request confidential communications and alternative means of communication with you.
- The right to request restrictions on certain uses of your health care.
- The right to inspect and copy certain medical information that we maintain about you.
- The right to request an amendment of your health information.
- The right to an accounting of certain disclosures of health information.

Change to the Notice: We reserve the right to change the Notice. We will post any revised Notice in the Hospital and Clinics.

Complaints: If you believe your rights have been violated, you may file a written complaint with the Hospital Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services.

### ACKNOWLEDGEMENT

Patient Acknowledgement: I acknowledge that I have received a copy of the Notice of Privacy Practices for Habersham Medical Center. In receiving the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Time/Date: \_\_\_\_\_ Signature of Patient: \_\_\_\_\_

For use by Hospital Personnel Only: (Complete if patient acknowledgement has not been obtained) The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An acknowledgement was not obtained because: \_\_\_\_\_

Time/Date: \_\_\_\_\_ Signature of Hospital Representative: \_\_\_\_\_



## MEDICAL HISTORY AND CURRENT SYMPTOMS

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY AND CURRENT SYMPTOMS

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Briefly explain the reason for coming to the clinic today: (List symptoms, duration, severity, and location):

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Please list below all current medications with dosage (include over the counter and herbal medications)

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Please list any allergies you have and the reactions you experience:

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Please list any surgeries you have had and the date of the procedures:

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Have you had Cancer? Yes / No If Yes, please list the type and treatment: \_\_\_\_\_

Have you had a colonoscopy? Yes / No If Yes, when and where: \_\_\_\_\_ Polyps? Yes / No

Tobacco Use: Yes / No How many years? \_\_\_\_\_ Type \_\_\_\_\_ Quite Date \_\_\_\_\_

Alcohol Use: Yes / No How many years? \_\_\_\_\_ Type \_\_\_\_\_ Quite Date \_\_\_\_\_

PLEASE LIST HEALTH PROBLEMS WITHIN YOUR IMMEDIATE FAMILY HEALTH HISTORY

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Brother: \_\_\_\_\_

Sister: \_\_\_\_\_

Grandparent: \_\_\_\_\_



## REVIEW OF SYMPTOMS

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

PLEASE CIRCLE ALL THAT APPLY TO THE PATIENT

Constitutional:	Appetite Change	Fever	Weight Gain	Fatigue
	Excessive Sweating	Night Sweats	Weight Loss	
Respiratory:	Cough	Shortness of Breath	Snoring	Coughing Blood
	Phlegm Production	Pain with Breathing	Apneas	
Cardiovascular:	Swollen Legs	Chest Pain		
Gastrointestinal:	Abdominal Pain	Vomiting	Constipation	Nausea
	Bloating	Trouble Swallowing	Diarrhea	Change in Bowel Habits
	Food Intolerance	Reflux/Heartburn	Black Stool	Bloody Stool
Urinary:	Change in Urinary Stream	Incontinence	Urinary Urgency	
	Painful Urination	Urinating at Night	Penile Discharge	
	Blood in Urine	Urinary Frequency	Sexual Dysfunction	
Skin:	Hair Changes	Pigment Changes	Rash	
	Lesions/Changes in Moles	Itching	Skin Changes	
Neurologic:	Abnormal Gait	Loss of Coordination	Seizures	
	Focal Weakness	Memory Problems	Slurred Speech	
	Headache	Numbness	Tremor	
Endocrine:	Excessive Thirst	Excessive Hunger	Excessive Urination	
Hematologic Lymphatic:	Bruising	Excessive Bleeding	Recurrent	Easy Bleeding
	Easy Bleeding	Enlarged Lymph Nodes		Infections
Allergic/Immunologic:		Eczema	Seasonal Allergies	Urticaria
Gynecological:	Painful Menstruation	Post-Menopausal	Nipple Discharge	