Broad Top Area Medical Center, Inc

PATIENT REGISTRATION FORM; NEW PATIENT

As a Federally Qualified Health Center, Broad Top Area Medical Center is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Not Reported/Refused if you do not wish to answer a specific question. Thank you for choosing Broad Top Area Medical Center as your health care provider.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Suffix: _____ **Social Security Number:** _____ **Date of Birth:** _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Domestic Partner □ Separated □ Other

Street Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Email:** _____ **Primary Phone:** □ Home □ Cell □ Work

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

□ I DO / I DO NOT authorize BTAMC to leave a detailed message n my answering machine.

Primary Language: □ English □ Spanish □ Sign Language □ Other _____

Level of Education: (please check highest level completed)

□ Did not complete high school/GED □ High school diploma/GED □ Some college, no degree □ Technical diploma

□ Associate degree □ Bachelor's degree □ Master's degree □ Doctorate degree

Student Status: □ Full-Time □ Part-Time

Employment Status: Employed □ Yes □ No □ Full-Time □ Part-Time □ Unemployed □ Other _____

Employer Name: _____ Phone Number: _____

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

Race: □ American Indian or Alaska Native □ Asian □ African American □ Caucasian □ Native Hawaiian or Pacific Islander □ Other _____

Ethnicity: □ Latino/Hispanic □ Non-Latino/Hispanic □ Not Reported/Refused

Sex: □ Male □ Female **Sex at Birth:** □ Male □ Female □ Ambiguous □ Not Reported/Refused

Gender Identity: □ Not Reported/Refused □ Female □ Male □ Transgender Female (Male-to-Female)
□ Transgender Male (Female-to-Male) □ Non-Binary (Identifying as any gender other than female or male)
□ Uncertain □ Other _____

Sexual Orientation: □ Not Reported/Refused □ Heterosexual/Straight □ Homosexual/Gay/Lesbian □ Bisexual
□ Uncertain □ Other _____

Emergency Contact

Patient's Relation to Contact: □ Child □ Parent □ Spouse □ Other _____

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Suffix: ____ **Street Address:** _____ **City:** _____ **State:**_____ **Zip:**_____

Primary Phone Number: □ Home □ Cell □ Work

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

Section 2: Patient Consent to Share Personal Health Information

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, HIPAA in order for your physician and the staff of BTAMC to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so.

I, _____ authorize Broad Top Area Medical Center to share my personal health information with the named persons below. **(Please check which information Broad Top Area Medical Center is authorized to share with each named person)**

Name _____ **Relation to Patient**_____ Phone **Number**_____

□ I DO / □ I DO NOT authorize BTAMC to leave a detailed message □ Medical □ Billing □ Scheduling □ All

Name _____ **Relation to Patient**_____ **Phone Number** _____

□ I DO / □ I DO NOT authorize BTAMC to leave a detailed message □ Medical □ Billing □ Scheduling □ All

Name _____ **Relation to Patient**_____ **Phone Number** _____

□ I DO / □ I DO NOT authorize BTAMC to leave a detailed message □ Medical □ Billing □ Scheduling □ All

Name _____ **Relation to Patient** _____ **Phone Number**_____

□ I DO / □ I DO NOT authorize BTAMC to leave a detailed message □ Medical □ Billing □ Scheduling □ All

Section 3: Guarantor (Financially Responsible Individual) Information

Guarantor is: □ Patient is Guarantor (no need to complete rest of the section) □ Person □ Company

Patient's Relation to Guarantor: □ Child □ Parent □ Spouse □ Employer □ Other _____

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Suffix: _____ Social **Security Number:** _____ Sex: □ Male □ Female

Date of Birth: _____ **Marital Status:** □ Single □ Married □ Widowed □ Divorced □ Other

Street Address: _____ **City:** _____

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

Primary Language: □ English □ Spanish □ Sign Language □ Other _____

Family Income and Shelter Information

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding Fee Scale, please complete separate Sliding Fee Application.

Income Period: □ Weekly □ Bi-weekly □ Monthly □ Bi-monthly □ Quarterly □ Annually □ Other_____

Gross Income for Period: $_____**Number of Individuals Income Supports:** _____ Disabled**:** □ Yes □ No

Homeless Status: □ Not Homeless □ Homeless Shelter □ Homeless-Transitional □ Homeless-Doubling up □ Homeless-Street □ Other

Worker Status: □ Migrant □ Not Migrant □ Seasonal

Veteran: □ Yes □ No

Treatment and Payment Authorization

You are responsible for your own bill. As a courtesy, Broad Top Area Medical Center will submit charges to your insurance carrier. If you have no insurance, you will be required to set up payment arrangements with our financial counselor.

- I authorize the release of any medical information needed to determine insurance benefits.
- I understand that charges not covered by my insurance company, as well as applicable co-payments, and deductible, are my responsibility. In the event of my default, or non-payment of my bill, I agree to pay all costs of collections, reasonable attorney's fees, and court costs due in addition to the amount due that may be attached. As the parent, guardian, or custodian of the patient, I agree to be responsible for all services rendered to minor patients.
- I understand that I am financially responsible for all charges whether or not they are covered by insurance.
- I understand that any returned checks by my financial institution will incur a $25.00 fee.
- I, the undersigned, agree to participate in clinical interviews, treatment, and testing as a patient of Broad Top Area Medical Center.
- I authorize treatment for my indentified minor or myself. I also understand that examination and treatment may be by a student, intern, or resident under the supervision of a clinician.

_____
Name: (Please Print)

_____ Date:_____
Patient/Guardian Signature

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatments and advice, and specific health information to:

1. **TREATING PHYSICIANS** on staff at BTAMC and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow-up care.

2. **AN EMPLOYER** who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol, or marijuana.
3. **EDUCATIONAL or SCIENTIFIC INSTITUTIONS** authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education, or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely effected and that I could be held liable for the full costs of services provided by BTAMC.

_____

Name: (Please Print)

_____ Date:_____

Patient/Guardian Signature

Print Name:_____

Patient Signature:_____ Date:_____

Office Use only/Data Entry

Staff Member:_____ Date:_____

Broad Top Area Medical Centers strictly prohibits video and voice recording of consultations and will not be tolerated at any time.

Privileged communication between the patient's and the physician's relationship is private and should remain confidential. The patient has an obligation to be honest with their provider; just as it is the physician's duty to be fair and honest in their patient's care. Informed consent must be expressed, mutually to disclose Protected Health Information (PHI) at any time.

Potential Adverse Outcomes of Recording:

Recording may inhibit free and trustful information exchange.

Recording may hinder a patient's acknowledgment of recent events or problems that they perceive, might affect their independence if they know family members may access the information.

Recording might create fear for a patient about physical conditions being revealed when found on physical examination.

Recording may prompt providers to become guarded and introduce defensive medicine in a previously, trusting relationship.

Recording may mutually affect the patient's reciprocal sense of trust.

Recording could inadvertently, record Protected Health Information (PHI) about other, unrelated parties within the office.

Implementation:

To insure confidentiality and privacy of patients, their family and caregivers, our employees and **ALL** Protected Health Information (PHI) electronic recording is strictly prohibited. As a patient, family member, or caregiver, I agree to adhere to this policy by signing below.

Your provider will create a printed record of your visit or a copy of the visit summary with a signed authorization to release information.

_____	_____	_____
Name (please print)	Signature:	Date:
_____	_____	_____
Name (please print)	Signature:	Date:

New Patient Intake form

We would like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health care needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

New Patient Medical History - Please complete this form prior to your first appointment

Name: _____ Date of Birth: ___/___/ ___ Age: ____ Sex: ____

How did you hear about our practice? _____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦			
Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Hypertension		❑ Cancer Type:_____ Location:_____	
❑ High Cholesterol		❑ Arthritis / RA / Lupus	
❑ Hypothyroidism (low thyroid)		❑ Depression / Mental Disorder / Nervous	
❑ COPD, Emphysema or Asthma		❑ Blood Clot/DVT/Pulmonary Embolus	
❑ Diabetes		❑ Kidney Disease	
❑ GERD		❑ Hepatitis / Liver Disease	
❑ Depression or Anxiety		❑ Ulcers / Stomach Problems	
❑ Heart Disease		❑ Epilepsy / Seizures	
❑ Usual Childhood Disease (Mumps, Chicken Pox, Measles)		❑ Mitral Valve Prolapse	
❑ Asthma / Respiratory Disease / TB		❑ Hemophilia/ Bleeding Problems /Anemia	

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦			
Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***

♦ Social History ♦

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		

Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children:				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

□ Vision problems	□ Wheezing	□ Lumps in breast	□ Frequent Urination	□ Excessive hunger
□ Hearing problems	□ Asthma / COPD	□ Breast discharge	□ Incontinence	□ Excessive thirst
□ Sinus trouble	□ Emphysema	□ Trouble swallowing	□ Blood in Urine	□ Weakness
□ Hay fever	□ Bronchitis	□ Nausea	□ History of STD's	□ Fatigue
□ Nosebleeds	□ TB exposure	□ Vomiting	□ Anemia	□ Fever / Sweating
□ Sore throat	□ Chest pain	□ Abdominal pain	□ Easy bruising	□ Fainting
□ Hoarseness	□ Chest discomfort	□ Hepatitis / Jaundice	□ Pain in legs	□ Seizures / Tremor
□ Lumps in neck	□ Shortness of breath	□ Gallstones	□ Joint pain / stiffness	□ *Headaches / Migraine*
□ Tooth problems	□ High blood pressure	□ Diarrhea	□ Blood clot	□ Numbness/tingling
□ Cough	□ Diabetes	□ Constipation	□ Weight loss / gain	□ Anxiety/Depression
□ Coughing blood	□ High cholesterol	□ Blood in stool	□ Heat/cold intolerance	□ Difficulty sleeping

☐ *Back Pain*	☐ *Nerve Pain*	☐ *Muscle Aches and Pain*	☐ *Arthritis / Joint Problems*	☐ *Cancer*
☐ *Other Cause of Chronic Pain*	☐ *Learning or Attention Problems*	☐ Strokes	☐ Liver Problems	☐ Thyroid Problems
☐ Eye Problems	☐ Heart Problems	☐ Reflux / Stomach Problems	☐ Kidney Problem	

♦ **Disease Prevention and Health Maintenance** ♦ Please list below the most recent dates of your vaccines and health screening tests					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Heart Catheterization	
Pneumonia Vaccine		Pap Smear		Stent Placement	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Echocardiogram	
Gardasil Vaccine		Eye Exam			