SOLID OAK ADULT AND PEDIATRIC CLINIC

PATIENT REGISTRAITION

Please fill in all information completely. If this does not apply, please put N/A.

Patient's Legal Name: Last_____ MI____ First_____

Date of birth: _____ Social Security #_____

Maiden Name _____ Preferred Name_____

Patient's Mailing Address_____

City_____State_____Zip_____

Email Address (Required) _____

Home # (____)_____Cell # (____)_____Work #(____)_____

Sex: Male/ Female **Marital Status:** Single/ Married/ Widowed/ Divorced

Contact Preference: Home Phone/ Work Phone/ Mobile Phone/ Mail/ Portal

Ethnicity: _____Language: _____ Race:_____

Emergency Contact: _____ Phone # (____)_____

Relationship to Patient: _____

PARENT OR GUARDIAN RESPONSIBLE FOR PATIENT

Responsible Party Name_____

DOB:_____ Responsible Party Social Security # _____

Billing Address_____

City_____State_____Zip_____

Home Phone #(____)_____ Relationship to Patient _____

Financial Policy

Payment is due when services are rendered. **IF WE PARTICIPATE IN YOUR INSURANCE PLAN,** your co-pay or deductible needs to be paid at the time of visit. **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE,** as a courtesy to you, our office will be happy to submit your claim to your insurance company for your reimbursement. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carrier to establish why they have not paid or why they paid less than originally indicated. If your insurance carrier pays in excess of the balance, we will refund the credit amount to you. You will also be responsible for any other cost incurred while collecting any outstanding balances. By signing below you are accepting all financial responsibility for the above named patient.

**Authorization To Release Information **

By signing below you also authorize Solid Oak Adult and Pediatric to release any information acquired in the course of your treatment necessary to process insurance claims.

Signature: _____ **Date:** _____

(Patient's signature is required if over the age of 14)

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INSURANCE INFORMATION (FORM MUST BE UPDATED YEARLY)

Patient Name: _____ **DOB:** _____

Please be sure to have your Insurance Card and Driver's License at your appointment as we will need copies for our records as well as proof of insurance is required at any visit. If complete insurance information cannot be provided at the time of service, the patient's appointment will need to be rescheduled. By not providing complete insurance information, as well as filling out this form completely, you are consenting to pay in full the cost treatment.

PLEASE FILL OUT THIS SECTION COMPLETELY, LEAVING IT BLANK WILL RESULT IN PATIENT RESPONSIBILITY

Primary Insurance Co. Name_____

Subscriber's Name (Policy Holder)_____

Relationship to Patient_____

Address of Subscriber_____

Phone Number of Subscriber: _____

Subscriber's Social Security # _____Date of Birth: _____

Contract or ID #_____ Group: _____

Insurance Address: _____

Secondary Insurance Co. Name_____

Subscriber's Name (Policy Holder)_____

Relationship to Patient: _____

Address of Subscriber_____

Phone Number of Subscriber: _____

Subscriber's Social Security # _____Date of Birth: _____

Contract or ID #_____ Group: _____

Insurance Address: _____

** IF THIS IS A GI PATIENT AND YOUR INSURANCE REQUIRS A REFERRAL, IT IS YOUR RESPONSIBILITY TO MAKE SURE WE HAVE IT ON FILE BEFORE YOUR VISIT. IF YOU AGREE TO SEE THE DOCTOR WITHOUT A REFERRAL, YOU ARE ACCEPTING RESPONSIBILITY FOR THE CHARGES**

GI Patient School Excuses:

_____ You must call the office the day the patient is absent. Only three excuses will be allowed between visits
Initial

Signature: _____ **Date:** _____

(Patient's signature is required if over the age of 14)

SOLID OAK ADULT AND PEDIATRIC CLINIC

Patient Name: _____ DOB: _____

Any physician, staff, employee or representative of Solid Oak Adult and Pediatric has my permission to discuss and/or disclose information regarding my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information in order to facilitate and coordinate my care, treatment and payment with the following persons:

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Communicator Automated Messaging Preferences
(Circle preferred)

Health Notifications	Email	Phone	Text Message
Appointments	Email	Phone	Text Message
Announcements	Email	Phone	Text Message
Billing	Email	Phone	Text Message

Consent to Call: Yes / No Consent to Text: Yes / No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below. The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and request for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.
PATIENT RIGHTS: As a patient, you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment or health care operational purposes.
PROVIDER RIGHTS: As your health care provider, we can use or disclose your PHI for treatment, payment or health care operational purposes. Any other disclosure requires you to sign a specific authorization.
NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.
ACHKNOWLEDGEMENT: I acknowledge that I have received Alabama Pediatric Gastroenterology, P.C. Notice of Privacy Practices.

_____ Audio and Video recordings are not allowed. We feel that such recordings interfere with medical treatment and the privacy of our staff and patients.
Initial

Signature: _____ Date: _____
(Patient's signature is required if over the age of 14)

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MEDICAL HEALTH HISTORY QUESTIONNAIRE

Your answers on the form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important.

ALL QUESTIONS CONTAINED IN THE QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL.

Patient's Name:_____ **D.O.B:**_____

Please Check: ☐Internal Medicine ☐General Pediatrics ☐G.I. Patient

Main reason for today's visit: _____

Other concerns: _____

Please Check All That Apply: **PAST MEDICAL HISTORY**

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes- Insulin	High Cholesterol	Stroke
Diabetes- Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

PAST SURGICAL HISTORY

	SURGERY	REASON & YEAR
1.		
2.		
3.		
4.		

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1.		
2.		
3.		

SOCIAL HISTORY

1. __ Yes __ No Alcohol Consumption 2. __ Yes __ No Tobacco Consumption 3. __ Yes __ No Recreational Drugs

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Separated

Occupation: _____

MEDICATIONS

Please list all medication you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PHARMACY NAME/LOCATION/PHONE #:_____

Please add any additional information about your health that you would like your provider to know on the back of this form.