PATIENT REGISTRATION

(Please Print Legibly- All Fields REQUIRED)

Today's Date:	Date of Birth:	Primary Care Physician:
Last Name:	First Name:	Sex: ☐ M ☐ F ☐ Other
Mailing Address:	Physical Address (If different):	Social Security Number:
Cell Phone:	Home Phone:	Driver's License#:
Employer:	Occupation:	Employer Address:
Race:	Ethnicity:	Preferred Language:
How did you hear about us? ☐ Family ☐ Friend	☐ Drive by ☐ Yellow Pages ☐ Yelp ☐ Hospital	☐ Other: ____________

RESPONSIBLE PARTY

Name (First & Last): ____________	Date of Birth:	Phone #: ____________
Relationship to Patient: ____________	Social Security #: ____________	DL#: ____________
Address: ____________	City & State:	Zip:

EMERGENCY CONTACT

Name: ____________	Relationship: ____________	Phone #: ____________
Name: ____________	Relationship: ____________	Phone #: ____________

CONSENT TO TREAT

I voluntarily request a physician and/or mid-level (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Signature: ______________________________ **Date:** ____________

VISTA COMPLETE CARE

HEALTH HISTORY

CARE TEAM *Please list any other physicians you receive medical care from, including specialists*

____

____

ALLERGIES *Please list any medications you are allergic to:*

____

____

FAMILY HISTORY *Do any of your relatives have major health issues? If so, please complete the section below:*

Relation: ____________	Relation: ____________	Relation: ____________
Condition: ____________	Condition: ____________	Condition: ____________
Age of Onset: ____________	Age of Onset: ____________	Age of Onsent: ____________
Deceased Age: ____________	Deceased Age: ____________	Deceased Age: ____________

SOCIAL HISTORY *Please check the correct responses for each corresponding lifestyle habits:*

Smoking Status	Never Smoker ____ Former Smoker ____ Current Smoker ____
Smoking How Much?	None ___ 1 pack/week ___ 2 packs/week ___1/4 pack/day ___1 pack/day ___2 packs/day___3+ packs/day___
How many years did you or have you smoked?	___________
Occupation?	___________
Alcohol Intake	None ____ Occassional ___ Moderate____Heavy ____
Caffeine Intake	None ____ Occassional ____ Moderate ____ Heavy ____
Chewing Tobacco	None ____ 1/day____ 2-4/day ____5+/day ____
Exercise Level	None ____ Occassional____ Moderate____ Heavy____
Do you have an Advance Directive?	YES ____ NO____
Date of your last menstrual cycle	(if applicable):

SURGICAL HISTORY *Please list any surgeries you have had, please include the date of surgery as well:*

____

____

____

PAST MEDICAL HISTORY *Please indicate if you have a history of the following conditions (circle all that apply):*

ADHD	COPD	Fibromyalgia	Kidney Disease
Allergies	Cancer	Gout	Osteoporosis
Anemia	Coronary Artery Disease	Headaches	Pulmonary Embolism
Arthritis	Depression/Anxiety	Heart Disease	Reflux/GERD
Asthma	Diabetes	High Cholesterol	Seizures/Epilepsy
Bladder Problems	Diverticulitis	Hypertension	Thyroid Problems

PRIVACY FORM & ACKNOWLEDGEMENTS

I,____________________________, hereby authorize **Vista Complete Care** , its employees and providers, to communicate with and release my Protected Health Information (PHI) described below to the person(s) indicated here:

Name: ____________________________ Relationship: __________________________ Phone Number: _______________________

Name: ____________________________ Relationship: __________________________ Phone Number: _______________________

Name: ____________________________ Relationship: __________________________ Phone Number: _______________________

Description of Health Information to be disclosed , upon the request of the person named above:

☐ **Disclose *ALL*** health records including, but not limited to, diagnoses, lab tests and results, prognosis, treatment plan, and billing, for all conditions.

-OR-

Disclose my complete health record as above, but ***DO NOT DISCLOSE*** the following (check all that apply):

☐ Mental Health Record(s) ☐ Communicable Diseases (including HIV and AIDS) ☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____________________________

Form of Disclosure will include: verbal (telephone or cell phone) AND written (electronic record, hard copy, and/or online portal) unless restricted method listed here: ______________________

I understand that I may revoke this authorization at anytime, but my revocation of this authorization MUST be done in writing and in person at Vista Complete Care 13555 Bowman Rd. Ste 100, Auburn, CA 95603. I also understand that my revocation does not affect disclosures made under this agreement prior to receiving said revocation. I also understand I have a right to receive a copy of this authorization. By signing below, I understand all of the above.

Signature: ____ **Date:** ________________________

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

By signing below, I acknowledge that I am ultimately financially responsible for services rendered at Vista Complete Care. I hereby assign my insurance benefits to be paid directly to the healthcare provider and I authorize Vista Complete Care to release information required to process my claim.

Signature: ____ **Date:** ________________________

OFFICE POLICIES AND PROCEDURES

By signing below, I acknowledge that I have received a copy of, have read and fully understand the Office Policies and Procedures.

Signature: ____ **Date:** ________________________

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of, have read and fully understand the Notices of Privacy Practices. I authorize Vista Complete Care to obtain/have access to my healthcare and medication history.

Signature: ____ **Date:** ________________________

Legal Representative (If Applicable)

By my signatures on this page, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g. Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to all of the authorizations on this form.

Name of Legal Representative: ___________________ **Signature of Legal Representative:** _______________________________

Name of Witness: ___________________________ Signature of Witness: ________________________________ Date: ________________