New Patient Registration

Patient Name: Last	First	Middle	
Address:	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) □ Male □Female	Date of Birth	Social Security #	Driver License #
Marital Status (check one) □ Single □ Married □Divorced □ Widowed	Spouse's Name (If Applicable)	E-mail Address:	
Race □ American Indian or Alaska Native □ Black or African American □ White □ Asian □ Multiracial □ Decline □ other			Language
Ethnicity □ Hispanic □ Latino □ Decline	Emergency Contact	Phone #	
How did you hear about the physician you are seeing today? □ Family/Friend □ Hospital □ Internet/Website □ Physician Referral □ Insurance □ Location/ Drive By □ Other _____			
Pharmacy Name:	Pharmacy Phone #		
Responsible Party: Last	First	Relationship	
Social Security #	Employer	Date of Birth	
Primary Insurance Company		Claims Address	
Policy ID Number Group ID		Phone	

Complete this section ONLY if patient is a minor

_____ Date of Birth: ___/___/____ Social Security # _____-_____-_____ Relationship: _____

Parent/ Legal Guardian

_____

Signature of Parent/Legal Guardian Date

I hereby authorize employees and agents of White Rock Family Health, including physicians, nurse practitioners and other employees to render medical evaluations and care.

I hereby authorize payment of medical benefits directly to White Rock Family Health and/or the physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance company.

The Health Insurance Portability and Accountability Act (HIPPA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. The Notice of Privacy Practices is displayed for review and I understand that I am entitled to receive a copy of this document.

Payment is due at the time of service and will be collected during the check in process. We accept cash, check and credit card. Valid government photo identification is required for all transactions. A $35.00 fee applies to for returned checks.

_____

Signature of Patient, Parent or Legal Guardian Date

Patient Name: _____ D.O.B _____

Please list below any person(s) WRFH may contact (by checking the box) if we may discuss any information related to your **billing account** and/or **medical conditions**. Also, choose the person you would like us to list as your **emergency contact** in the event an emergency situation was to take place at our office.

_____ _____ _____ □ Billing □ Medical Information □ Emergency Contact
Name Relationship Phone

_____ _____ _____ □ Billing □ Medical Information □ Emergency Contact
Name Relationship Phone

☐ DO NOT disclose or discuss any information related to my billing account or medical conditions with anyone other than myself, except in an emergency situation.

☐ **I do not wish** to be notified by any other communication method requarding my medical conditions. I request that communication regarding my medical conditions to occur **ONLY** when I am in the clinic.

My preferred method of communication regarding my medical condition is indicated below (check one):

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Mailed Letter ☐ Other: _____

If the above method of communication is by phone, please check the appropriate box below:

☐ OK to leave a message with detailed information. ☐ Please leave a message with a call back number only.

Use of Electronic Communication from WRFH to the patient

☐ Yes, I want WRFH to communicate my information with me through WRFH patient portal. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clinking on the link, you will be required to log in and provide a password to access your information. You will need to make note of the password to access any future information.

Please enter in the space below the e-mail address you want to use to receive the notification that there is information awaiting your review: _____

☐ No, I **do not** want WRFH to use electronic communication as a way to communicate my information to me.

Prescription History Consent

I authorize White Rock Family Health and its affiliated providers to access and use my prescription history for treatment purposes. Prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable and it may include prescriptions dating back for several years.

I acknowledge that White Rock Family Health may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

_____
Signature Date

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require authorization prior to the disclosure of any medical information.

_____
Signature of Patient, Parent or Legal Guardian Date

_____ _____
Name of Patient, Parent or Legal Guardian Relationship to Patient

The following forms will allow us to learn more about your medical problems. Please fill in the bubbles that pertain to your current medical conditions. The bubbles will need to be filled in completely.
Thank you.

Examples:  correct  incorrect  incorrect

	Self	Father	Mother	Siblings
Past Medical History				
Diabetes Mellitus	O Yes	O Yes	O Yes	O Yes
Hypertension	O Yes	O Yes	O Yes	O Yes
Cholesterol	O Yes	O Yes	O Yes	O Yes
Arrhythmia	O Yes	O Yes	O Yes	O Yes
Heart attack	O Yes	O Yes	O Yes	O Yes
Congestive Heart failure	O Yes	O Yes	O Yes	O Yes
Thyroid Disease	O Yes	O Yes	O Yes	O Yes
Kidney Disease	O Yes	O Yes	O Yes	O Yes
Asthma	O Yes	O Yes	O Yes	O Yes
Emphysema	O Yes	O Yes	O Yes	O Yes
Chronic bronchitis	O Yes	O Yes	O Yes	O Yes
Liver Disease	O Yes	O Yes	O Yes	O Yes
Blood Clots	O Yes	O Yes	O Yes	O Yes
Breast cancer	O Yes	O Yes	O Yes	O Yes
Colon cancer	O Yes	O Yes	O Yes	O Yes
Seizures	O Yes	O Yes	O Yes	O Yes

Travel Outside US:	O Yes	O No
Smoking:	O Yes	O No
Alcohol:	O Yes	O No
Drug use:	O Yes	O No
Exercise:	O Yes	O No
Seat belt use:	O Yes	O No

Other medical conditions: _____

_____

_____

CONSTITUTIONAL

Fever	O Yes	O No
Chills	O Yes	O No
Weakness	O Yes	O No
Body Aches	O Yes	O No
Weight Gain	O Yes	O No
Weight Loss	O Yes	O No

NEUROLOGY

Headache	O Yes	O No
Weakness	O Yes	O No
Tingling/Numbness	O Yes	O No

DERMATOLOGY

Rash	O Yes	O No
Bruising	O Yes	O No
Hives	O Yes	O No

ENT

Runny Nose	O Yes	O No
Nose bleeds	O Yes	O No
Cough	O Yes	O No
Sinus Pain	O Yes	O No
Sore Throat	O Yes	O No
Hoarseness	O Yes	O No
Teeth Pain	O Yes	O No
Hearing Loss	O Yes	O No

ALLERGY

Sneezing	O Yes	O No
Itchy Eyes	O Yes	O No

OPHTHALMOLOGY

Eye Redness	O Yes	O No
Blurred Vision	O Yes	O No
Vision Loss	O Yes	O No

CARDIOLOGY

Chest Pain	O Yes	O No
Irregular Heart Beat	O Yes	O No
Palpitations	O Yes	O No
Leg Edema	O Yes	O No

RESPIRATORY

Shortness of Breath	O Yes	O No
Wheezing	O Yes	O No
Persistent Cough	O Yes	O No

GASTROENTEROLOGY

Stomach Pain	O Yes	O No
Stomach Ulcer	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Blood in Stool	O Yes	O No

UROLOGY

Urinary Frequency	O Yes	O No
Urinary Incontinence	O Yes	O No
Blood in Urine	O Yes	O No
Urinary Urgency	O Yes	O No
Painful Urination	O Yes	O No

FEMALE REPRODUCTIVE

Painful periods	O Yes	O No
Irregular Menses	O Yes	O No
Hot Flashes	O Yes	O No
STDs	O Yes	O No

MALE REPRODUCTIVE

Difficulty with Erection	O Yes	O No
Urgency/Frequency	O Yes	O No
STDs	O Yes	O No

MUSCULOSKELETAL

Muscle Aches	O Yes	O No
Back Pain	O Yes	O No
Joint Pain	O Yes	O No
Joint Swelling	O Yes	O No
Leg Cramps	O Yes	O No

PSYCHOLOGY

Depression	O Yes	O No
Anxiety	O Yes	O No
Hallucinations	O Yes	O No
Sleep Disturbances	O Yes	O No

HEMATOLOGY/LYMPH

Swollen Glands	O Yes	O No
Fatigue	O Yes	O No
Easy Bruising	O Yes	O No

ENDOCRINOLOGY

Excessive Thirst	O Yes	O No
Excessive Hunger	O Yes	O No
Skin Changes	O Yes	O No
Hair Changes	O Yes	O No