**Registration Form**

**DEMOGRAPHICS**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:

Preferred Language (If other than English): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnicity:

**EMERGENCY INFORMATION**

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Closest Relative not living with you –

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

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

**PHARMACY/PRIMARY CARE PHYSICIAN**

Pharmacy Name: Pharmacy Phone:

Pharmacy Address:

Name of Current or Prior Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

**INSURANCE**

Primary Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group: Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group: Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Legal Guardian/POA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES** (Please list allergy and reaction)

**CIRCLE OF CARE** (Please identify the specialists that you are currently seeing and provide name)

* Allergist
* Behavioral Health
* Cardiology
* Dermatology
* Endocrinology
* Ear, Nose, Throat
* Gastroenterology
* GYN/OBGYN
* Hematology/Oncology
* Infectious Disease
* Nephrology
* Neurology
* Orthopedic
* Pain
* Physical Therapy
* Podiatry
* Pulmonology
* Rheumatology
* Urology
* OTHER

**PAST MEDICAL HISTORY** (Please check any medical conditions you have been diagnosed with in the past)

|  |  |  |
| --- | --- | --- |
| O Anxiety Disorder | O Has Pacemaker | O Mental Disease |
| O Asthma/Wheezing | O Epilepsy | O Osteoporosis |
| O Arthritis/Gout | O Gallbladder Disease | O Skin Disease |
| O Blood Disorder(s) | O Glaucoma/Blindness | O STD’s (VD) |
| O Bronchitis/Pneumonia | O Heart Disease | O Stroke/TIA |
| O Cancer | O Hemorrhoids | O TB/TB Exposure |
| O Colitis | O Hepatitis or Jaundice | O Thyroid Disease |
| O COPD | O High Cholesterol | O Transfusion – Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| O Diabetes | O Hypertension | O Ulcers |
| O Drug/Alcohol Addiction | O Kidney Disease | O Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |

**PAST SURGICAL/HOSPITAL**

|  |  |
| --- | --- |
| Past Surgeries/Hospitalizations | Date of Surgery/Hospitalization |
|  |  |
|  |  |
|  |  |
|  |  |

**SOCIAL HISTORY**

Do you use tobacco? O YES – Pack per day \_\_\_\_\_\_\_\_\_\_\_ O NO

Do you drink alcohol? O YES – Drinks per day\_\_\_\_\_\_\_\_\_\_\_ O NO

Do you drink caffeine (coffee, tea, colas)? O YES – Drinks per day\_\_\_\_\_\_\_\_\_\_\_ O NO

**PREVENTATIVE HEALTH/IMMUNIZATION HISTORY**

□ Measles □ Mumps □ Rubella □ Hepatitis A and/or B □ Polio □ Tetanus

□ Shingles Last Vaccination Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Flu Last Vaccination Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Pneumonia Last Vaccination Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Covid Last Vaccination Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Bone Density Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Eye Exam Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Mammogram Date \_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_

□ Pap Smear Date \_\_\_\_\_\_\_ Where

**MEDICATIONS/PRESCRIPTIONS** (including vitamins and supplements)

|  |  |  |
| --- | --- | --- |
| Drug | Dose | How Often |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FAMILY HISTORY** (please list any known conditions your immediate family members had/have)

|  |  |
| --- | --- |
| Relationship | Condition |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Authorization for Use or Disclosure of Protected Health Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects sensitive patient health information from being disclosed without the patient’s consent or knowledge. The purpose of this form is to identify the circumstances you authorize the disclosure of such sensitive information.

I hereby authorize the of release medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information as it concerns the above referenced patient as follows:

To: (check all that apply):

□ My spouse/partner Name of spouse/partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ My Physician/staff Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ My Pharmacy Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ My parent/child(ren) Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ My Personal Representative Name of Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ None of the above

I authorize the office/provider to communicate via the below methods (*please circle yes or no for each method listed below*):

Yes No Leave a voicemail message at the provided phone numbers

Yes No Text me at the provided phone numbers

Yes No Email me at the provided address

***Please circle yes or no for each of the below***

**Yes or No** I authorize the Practice to use or disclose my protected health information (PHI), including my name, phone number, mailing address and email account listed below, to communicate with me about the Practice’s products, services, community events or other general health information. I understand that these communications may be considered marketing communications, and that I will have the opportunity to opt-out of these communications at any time. The practice will/will not receive financial remuneration in relation to these communications. I also understand that mail, text message, and email are not secure and may be intercepted by unauthorized parties, and specifically authorize the Practice to communicate with me about products, services, community events, or other health information via phone, text message, email or regular mail. I understand that some of these communications may result in charges from my telecommunications provider.

**Yes or No** I further authorize the Practice to take photos, videos, and recordings to of me (or person for whom I am legal guardian), and specifically authorize the Practice to disclose such images for marketing purposes, including, on social media sites, in journals, publications or other educational materials, in marketing publications, in electronic or paper form, and in medical publications/treatment examples for other patients. I understand that by authorizing the disclosure of images of me (or persons for whom I am legal guardian), the images may be seen by members of the general public, in addition to scientists, and medical researchers that regularly use publications in their professional education, as well as use for marketing purposes including, without limitation, website marketing, newspaper and television advertising. I understand that it is possible that someone may recognize me (or person for whom I am legal guardian). I acknowledge that the Practice is the sole owner of all rights in and to the photos, videos, and recordings, in whatever format they are in. The Practice has the right, among other things, to edit and otherwise alter the photos, videos, and recordings, as deemed needed or desirable. I understand that this authorization applies to any photos, videos and recordings that were taken or used by the Practice prior to the date of my signature below. I understand I will receive no compensation for the Practice’s use of the photos, videos and recordings.

**Authorization for Use or Disclosure of Protected Health Information**

Are there any restrictions on PHI to be disclosed? □Yes □ No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my revocation will not affect any actions taken prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 50 years from the date signed, at which time this authorization to obtain and release this protected health information expires.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Patient Signature or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Printed

Relationship to patient if not patient

***For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above, and attach proof of your authority to act on the patient’s behalf (other than natural parents).***

**Patient Care Agreement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the medical care and treatment tendered to the patient as deemed necessary or advisable in the judgment of the MAXHealth (“MAXHealth”) physician or other health care provider. I understand that, prior to rendering treatment, the physician or other health care provider will explain my medical care and treatment, including an explanation of treatment alternatives and the risks associated with such treatment. I acknowledge and consent to the following:

1. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: I hereby expressly authorize MAXHealth and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to MAXHealth and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignments shall remain valid unless I provide written notice of revocation to MAXHealth and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
2. NOTICES OF PRIVACY PRACTICES: I acknowledge I have received a copy of MAXHealth’s Notice of Privacy Practices on or before the date signed below. A copy of MAXHealth’s Notice of Privacy Practices is also located here: mymaxdoc.com.
3. PAYMENT FOR SERVICES: I agree to pay MAXHealth for services rendered. If I am insured by a health insurance plan in which Best Value participates, Best Value will submit a claim to my insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, and not MAXHealth. I understand that I am responsible for any charges denied by my insurance carrier along with any charges classified by my insurance carrier as a deductible, co-payment, and/or coinsurance.

**By signing this document, I certify that I have read, understand and agree to its contents and that information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.**

**Patient/ Representative** [Print]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/ Representative**  [Signature]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE [mm/dd/yyyy]**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed by patient, please provide documentation of legal representative status:

Attached: [ ] Do not have copy: [ ]

**Authorization to Release Healthcare Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security: ###-##-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize my healthcare information to be:

**Release to:**  **Release from:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION TO BE PROVIDED** (check one or more):

[ ]  All Medical Records/Information

[ ]  Abstract

[ ]  Billing records

[ ]  Outpatient Record

[ ]  Diagnostic Test/Results

[ ]  History & Physical

[ ]  Discharge Summary

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do not include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unless indicated above, I acknowledge that this request specifically includes medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information if in the possession of MAXHealth (“MAXHealth”).

***Please include date(s) of service from***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (records will be provided for all service dates if left blank)

**FORMAT**

I request that the copy be provided (where possible/available):

[ ]  On paper [ ]  In an electronic format [ ]  Discuss my medical information only [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If requesting an unencrypted format, by signing below you acknowledge that you understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties. I understand there may be a fee for a copy of my health information. All fees will be in compliance with applicable law.

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

THIS AUTHORIZATION EXPIRES WHEN THE PATIENT IS

NO LONGER UNDER THE CARE OF THE FACILITY REFERENCED ABOVE