Memorial Wellness CENTER

PATIENT REGISTRATION FORM

Today's Date: _____/_____/_____

PATIENT INFORMATION

Patient Name Last First Middle		**[ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms.**	**Marital Status (Circle)** Single Married Divorce Separated Widow	
Is this your legal Name? [ ] Yes [ ] No	**If not what is your legal name?**	**Birthdate: / /**	**Age:**	**Sex (Circle)** Male Female Transgender
Street or Mailing address (Circle one) City State Zip Code				**Social Security Number: -- --**
Home/Alt Phone Number:	**Cell Phone Number:**	**Email address:**		
Occupation:	**Employer:**		**Employer phone number:**	

Employment Status (Circle one): Full Time Part-Time Not Employed Self- Employed Retired Active Military

Student Status (Circle one): Full Time Student Part Time Student Not a Student

Race (Circle): American: Indian Alaska Native Asian Native Hawaiian/Pacific Islander Black/African American White Hispanic Other Decline

Ethnicity (Circle): Hispanic or Latino Not Hispanic or Latino Decline

Language (Circle): English Spanish Indian Japanese Chinese Korean French German Russian Other:_____

Pharmacy Name:	**Pharmacy Location:**	**Do you have a Living Will? [ ] Yes [ ] No**

Referred by (Circle one): Dr.:_____ Insurance Hospital Family Friend Yellow Pages

Other:_____

Other Family Member seen here: _____

PCP Name:	**Phone number:**

RESPONSIBLE PARTY INFORMATION

Responsible Party (Circle one): Another Patient Guarantor Self [ ] Check here if information is same at patient

Name:		**Address:**	**Home Phone Number:**
Birth Date: / /	**Email address:**		**Cell Phone Number:**
Occupation:	**Employer:**	**Employer Address:**	**Employer Phone Number:**

INSURANCE INFORMATION

Is this visit for one of the following (Circle one): Workers Compensation (WC) Occupational Medicine (OM) Motor Vehicle Accident (MVA)

Accident Date: _____

Does this person have Health Coverage (Circle one): Yes No			**Insurance Name:**		
Name of Insured:	**Social Security Number:**	**Birth Date: / /**	**Effective Date:**	**Group ID:**	**Subscriber ID (Policy number)**

Patient relation to insured (Circle one): Self Spouse Child Other: _____

Name of Secondary Insurance:	**Name of Insured:**	**Date of Birth: / /**	**Group ID:**	**Subscriber ID (Policy number)**

Patient relation to insured (Circle one): Self Spouse Child Other: _____

EMERGENCY CONTACT

Name (Last, First):	**Relationship to Patient:**	**Home Phone Number:**	**Other Phone Number:**

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date

_____

MWC Representative

Memorial Wellness CENTER

2100 S. Triviz, Suite F Las Cruces, NM 88011 Phone: 575.556. 1849 Fax: 575.532.2030

HIPAA Acknowledgment, Patient Consent and Financial Policy

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or repost an exposure to my blood or body fluids, my bold will be tested for blood borne infections including Hepatitis Band C as well as IV /SIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledged that no guarantees have been made to me as a result of treatment or examinations. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about ow we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The clinic proves this form to comply with the health information Portability and Accountability Act of 1996 (HIPAA).

☐ **Patient Initials**

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or use for treatment, payment, or health care operations.
- The practice reserve the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that his does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **Election to Electronically Transmit Medical Information:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/ or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy, notes), genetic testing information, and/ or abortion-related information. The summary of care record consist of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization.
This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and the subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions to any health information's exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which

V. Clinic participates may be found in the notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and to the information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependency, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

VI. **EMAIL AND TEXT COMMUNICATIONS:** if at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, services, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practices' healthcare team, and to provide general health reminders/information.

VII. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referend to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned herby assigns to the medical practice all insurance benefits the services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. If you do not have insurance, payment in full will be expected at the time of the visit.
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.
- If your Insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VIII. **PATIENTS CERTIFICATION, AUTHORAZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII, of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgment and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative ***Signature of Patient or Representative***

_____ _____

Date ***Relationship to Patient (if other than patient)***

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known: _____

_____

_____ _____

Witness (Staff) Printed Name ***Witness (Staff) Signature***

Date: _____

Memorial Wellness CENTER

❑ Melissa M. Livingston, DNP, FNP-BC
❑ Angelina Morales, DNP, FNP-BC

PATIENT NAME _____

DATE OF BIRTH _____ /_____ / _____ DATE OF VISIT _____ /_____ / _____

Review of Systems (please check all that apply)

CONSTITUTIONAL
❑ Chills
❑ Energy Level
❑ Low ❑ Normal ❑ High
❑ Fatigue
❑ Fever
❑ Weakness
❑ Weight Gain/Loss

SLEEP
❑ Snoring
❑ Frequent Naps
❑ Sleep Apnea (BIPAP/CIPAP)
❑ Morning Headaches
❑ Night Time Arousal

EYES
❑ Blurry of Vision
❑ Change in Vision
❑ Dry Eyes
❑ Wears glasses/contacts

EARS, NOSE, MOUTH, & THROAT
❑ Painful Chewing
❑ Hearing Loss
❑ Ringing in Ears
❑ Nasal Congestion
❑ Difficult Swallowing
❑ Dry Mouth
❑ Sore Throats

RESPIRATORY
❑ Cough
❑ Dyspnea Upon Exertion
❑ Hemoptysis
❑ History of Asthma/Chronic Obstructive Pulmonary Disease (COPD)
❑ Orthopnea
❑ Shortness of Breath
❑ Sputum
❑ Wheezing
❑ Painful Breathing

CARDIOVASCULAR
❑ Change in Exercise Tolerance
❑ Chest Pain
❑ Leg Swelling
❑ Pain the Leg while Walking
❑ Palpitations
❑ Home Oxygen

GASTROINTESTINAL
❑ Abdominal Pain
❑ Change in Bowel Movement
❑ Constipation
❑ Diarrhea
❑ Heartburn
❑ Indigestion
❑ Nausea

FEMALE REPRODUCTIVE
❑ Heavy Menses
❑ Amenorrhea
❑ Frequent Yeast Infections
❑ Hot Flashes
❑ Infertility
❑ Post-menopausal

MALE REPRODUCTIVE
❑ Difficulty with Erection

GENITOURINARY
❑ Night Time Frequency
❑ Urinary Urgency
❑ Urinary Incontinence
❑ Sexual Difficulty

MUSCULOSKELETAL
❑ Back Pain
❑ Joint Pain
❑ Morning Stiffness
❑ Muscle Aches
❑ Neck Pain
❑ Pain with Movement

INTEGUMENTARY
❑ Rashes/Open Sores/Lesions
❑ Breast Enlargement
❑ Change in Skin

NEUROLOGICAL
❑ Dizziness/Vertigo
❑ Gait Abnormality
❑ Headache
❑ Migraines
❑ Sleep Problems
❑ Tingling/Numbness

PSYCHIATRIC
❑ Anxiety
Receiving Counseling ❑ Yes ❑ No
❑ Depression
❑ Eating Disorder
❑ High Stress Level
❑ Mental/Physical Abuse
❑ Panic Attacks

ENDOCRINE
❑ Cold Intolerance
❑ Heat Intolerance
❑ Hot Flashes

ALLERGIC
❑ Food Allergies
❑ Infections

DERMATOLOGIC
❑ Easy Bleeding When Cut
❑ Bruising
❑ Dry or Sensitive Skin
❑ Excessive Hair Growth
❑ Hair Loss
❑ Itching
❑ Rash

Memorial Wellness CENTER

Date of Visit: _____ **[INITIAL]**

Patient Name: _____

Date of Birth: _____/_____/_____

NUTRITION AND EATING HABITS QUESTIONNAIRE

Why are you pursuing weight loss and/or surgery?

_____
_____
_____

What expectations do you have losing weight?

_____
_____
_____

What are your personal goals for losing weight?

_____
_____
_____

HORMONE HISTORY

Female: Have you ever had any of the following? Please check (√) all that apply.

[ ] Infertility [ ] Irregular Menstrual Cycle [ ] PCOS [ ] Changes in hair growth
[ ] Hormone Replacement Therapy [ ] Increased Sweating of Flushing
[ ] Menopausal Symptoms [ ] Decreased Libido [ ] Orgasms

Male: Have you ever had any of the following? Please check (√) all that apply.

[ ] Breast Development [ ] Low Testosterone [ ] Decreased Libido
[ ] Erectile Dysfunction [ ] Difficulties with ejaculation [ ] Orgasms

Are you currently sexually active?

WEIGHT HISTORY

What kind of diets have you tried?

_____
_____
_____

What strategies were successful, why or why not?

_____
_____
_____

List any medications you have tried in the past for weight loss:

_____
_____
_____

Have you had surgery to help you lose weight?

_____
_____

Are you satisfied with your weight? _____

How has your weight affected your health or current health conditions?

_____
_____

Has your weight changed in the last year? _____
_____
If yes, did you gain or lose and why?

_____
_____

What do you think is a realistic weight for you? _____pounds.

How long has it been since you were at that (realistic) weight? _____

What is your highest weight? _____ When were you at this weight? _____
Usual Weight: _____ Desired Weight: _____
Weight Lost/Gained: _____

Do you use any meal replacement products (drinks, bars, formulas)? [ ] No [ ] Yes
If yes, list the types, how often you take them and nutrition information (calories, grams of protein, grams of carbohydrate, grams of sugar, grams of total fat).

_____
_____

EATING HABITS

What is your largest meal of the day? _____

Do you have difficulty swallowing or chewing food? _____
_____
_____

Describe your appetite {hungry, not hungry, force myself to eat):

_____
_____
_____

Every day, do you usually eat:
Breakfast? [ ] No [ ] Yes If yes, when do you usually eat? _____
Lunch? [ ] No [ ] Yes If yes, when do you usually eat? _____
Dinner? [ ] No [ ] Yes If yes, when do you usually eat? _____
Snacks? [ ] No [ ] Yes If yes, when do you usually eat? _____

List any food allergies or intolerances:

_____

_____

On weekdays, how many meals do you eat in restaurants or get carry out?
How many breakfasts?_____ Lunches? _____ Evening Meals _____

On weekends, how many meals do you eat in restaurants or get carry out?
How many breakfasts?_____ Lunches? _____ Evening Meals _____

List restaurants where you often eat AND what you usually order:

_____

_____

_____

_____

Do you read food labels? [ ] No [ ] Yes If yes, what nutrients do you look for when you read food labels?

_____

_____

Have you ever been diagnosed with a nutritional deficiency? If so, please explain.

_____

_____

List all vitamins and minerals you are currently taking including herbs, fiber tables or powder, garlic pills, etc.:

_____

_____

Cultural influences or preferences with diet? If yes, please explain.

_____

_____

Describe any situations that influence your food intake, how and type of food consumed:

_____

_____

FOOD PREPARATION
Who prepares meals in your home and why?

_____

_____

Foods typically eaten daily

_____

_____

CRAVINGS
Do you crave any specific foods?

_____
_____

PORTION SIZES
Do you measure portion sizes? If so, how?

_____
_____

PHYSICAL ACTIVITY
Do you track your diet? [ ] No [ ] Yes If yes, which tracking system do you use (Fitbit, My Fitness Pal)? _____
Please ask us about how you can get a free subscription to **Cronometer.**

Do you exercise? [ ] No [ ] Yes If yes, please list below.			
Type of Exercise	How often each week?	How long is each exercise?	How many weeks or months have you been doing this exercise?

Is there any reason why you cannot exercise (pain, limitations, restrictions, heart or respiratory issues)? _____
_____

What integrative health approaches have you tried in the past (chiropractor, Reki, acupuncture, massage, herbalist, aromatherapy, other)?

_____
_____

Describe you energy level:

_____
_____

Describe a typical day:

_____
_____
_____

SLEEP HABITS
How many hours do sleep at night? _____

Do you take any naps? If so, how many and how many hours? _____

Do you have problems falling asleep, staying asleep or waking up?

_____

Do you wake up during the night? If yes, how many times, how long and why?

_____

ELIMINATION

How many times do you urinate daily? _____

Do you have issues regarding urination (incontinence, blood in urine, UTI's or yeast infections)

_____

_____

What is your normal bowel pattern?

_____

_____

Do you have any issues regarding bowel movements? (Constipation, diarrhea, IBS, straining)

_____

_____

Do any of your medication affect your bowel movements?

_____

_____

SOCIAL

What hobbies and leisure do you enjoy on your free time?

_____

_____

SOCIAL HISTORY

Highest Education Level Completed: _____

Occupation:

Do you have any physical or mental concerns today?

_____

_____

Please describe your support system?

_____

_____

Is there anything else you want the Provider to know?

_____

_____

_____

Memorial Wellness CENTER

24 HOUR DIET RECALL

Please list all foods and drinks you consumed yesterday

Meal or Snack	Time and Place	What did you eat and drink? (include amounts)
Breakfast / 1st meal		
Snack		
Lunch / 2nd meal		
Snack		
Dinner / 3rd meal		
Snack		
Other		

At home, how often do you eat food that is fried, stir-fried, or sautéed?

[ ] Never [ ] Less than 1 time a week [ ] Once a week
[ ] 2-4 times a week [ ] 5-6 times a week [ ] Daily

At home, what kind of fat do you use for frying and sauteing?

[ ] Butter [ ] Margine [ ] Olive oil
[ ] Other type of oil [ ] Cooking spray (PAM) [ ] Shortening or lard.

Please list any other food that you eat on a regular basis.

_____

_____

For each category of food types: Please list the number of servings you eat daily by **CIRCLING** the foods you eat most often. If daily does not match your response write how many servings weekly or monthly best describes how often you eat each food type within the category

VEGETABLES	**Servings/ day**
Nonstarchy vegetables	
Asparagus	
Artichokes	
Beets	
Broccoli	
Brussell sprouts	
Cabbage	
Carrots	
Cauliflower	
Celery	
Chile	
Cucumber	
Eggplant	
Green beans	
Mushrooms	
Okra	
Onions	
Peppers	
Summer squash (yellow or zucchini)	
Tomatoes	
Turnips	
Wax Beans	
Leaf Vegetables	
Salad greens	
Kale	
Mustard greens	
Spinach	
Sprouts	
Turnip greens	
Watercress	
Starch Vegetables - CARBS	
Corn	
Green peas	
Potatoes	
Sweet potatoes	
Yams	
Lentils	
Pumpkin	

Starch Vegetables – CARBS (cont)	
Winter squash	
Acorns	
Butternut	
Hubbard	
Dried Beans:	
Pinto	
Kidney	
White	
Garbanzo	
Black	
Brown	
Red	
Lima	
Baked beans	
Dried peas:	
Split	
Black-eyed	
Mixed Vegetables with corn, peas, or pasta	
FRUITS – CARBS *Fresh fruit, Canned fruit, Dried fruit, and Juice*	
Apple	
Apricot	
Banana	
Cherries	
Grapefruit	
Grapes	
Kiwi	
Mango	
Nectarine	
Orange	
Papaya	
Peach	
Pear	
Pineapple	
Plum	
Tangerine	
Other	

FRUITS – CARBS (CONT) *Fresh fruit, Canned fruit, Dried fruit, and Juice*	
Berries:	
Blackberries	
Blueberries	
Raspberries	
Strawberries	
Melons:	
Cantaloupe	
Honey dew	
Watermelon	

PROTEIN RICH FOODS	
Protein Foods	**Servings /Day**
Chicken: fried, breaded, grilled broiled	
Turkey	
Shrimp, lobster, crab or scallops	
Salmon, tuna tilapia or mackerel	
Ground beef, full fat, lean	
Steak, any cut	
Roasts and other cuts of beef	
Pork: ham, chops or loin	
Salami, bologna, or other lunch meats	
Deli ham, deli turkey, other deli meats	
Hot dogs	
Sausage	
Bacon	
Pepperoni	
Game meats	
Eggs	
Cheese all types (ricotta, cottage cheese, hard and soft)	
Peanut butter	
Peanuts	
Pecans, almonds, walnuts, pistachios and other nuts	
Tofu	

DAIRY AND DAIRY SUBSTITUTES – CARBS AND PROTEIN	
Food Types	**Servings/ Day**
Milk all types	
Yogurt, all types	

FATS AND OILS	
Food types	**Servings Per Day**
Margarine	
Butter	
Cream cheese	
Mayonnaise	
Olive oil	
Sour cream	
Salad Dressing – creamy, oil based or vinaigrettes	

GRAINS AND GRAIN PRODUCTS – CARBS	
Foods	**Servings/ Day**
Bread, all types	
Bagels	
Tortillas, flour, wheat, corn	
Rice: white, brown, or wild	
Pasta, all types	
Cereal, cold	
Cereal, cooked/hot	
French fries	
Potatoes, regular and/or sweet	
Crackers	
Chips	
Pretzels	
Popcorn	

COMBINATION FOODS – CARBS	
Foods	**Servings /Day**
Burritos, Enchiladas	
Casseroles	
Pasta Salads	
Pizza	
Pot Pies	
Lasagna	
Soup: cream, broth based	

DESSERTS, SWEETS AND SUGAR – CARBS	
Foods	**Servings Per Day**
Brownies, cakes	
Cookies	
Donuts, danishes, and other pastries	
Pie	
Pudding Custard	
Gelatin, regular, sugar-free	
Ice Cream, sherbet, frozen yogurt	
Popsicles: regular, sugar-free	
Milkshakes, other frozen desserts	
Candy: chocolates or other	
Honey, jam or jelly	
Pancake syrup	

BEVERAGES	Servings Per Day
Coffee drinks: coffee, latte, Frappuccino, etc.	
Hot cocoa	
Punch or lemonade	
Low calorie drinks/artificial sweeteners. Crystal Light, diet soda	
Soda regular 12-oz serving	
Beer, regular or light 12-oz servicing	
Wine 5-oz serving	
Hard liquor 1 shot serving	
Mixed drinks or cocktails	

Please list any other foods that you eat on a regular basis:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____