PATIENT REGISTRATION FORM

Las Cruces PHYSICIAN PRACTICES

Today's Date ____/____/____

PATIENT INFORMATION				
Patient Name Last First Middle			□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one)	City	State	Zip Code	Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy:	**City:**	Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION			
Responsible Party: □Another Patient □Guarantor □Self			□Check here if information is same as patient
Name	Address		Home Phone Number
Birth Date / /	E-Mail Address		( )
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO	**Insurance Name**				
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured □ 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

Las Cruces
PHYSICIAN PRACTICES

HIPAA ACKNOWLEDGEMENT, 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 report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. 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 how 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 provides 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 used for treatment, payment, or health care operations.
- The practice reserves 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 this 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 consists 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 their 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 thereof to any health information 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 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 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. 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.

V. **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, servicers, 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 Practice's healthcare team, and to provide general health reminders/information.

VI. **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 referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for 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.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: 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 Acknowledgement 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) Signature Witness (Staff) Printed Name

Date: _____

Memorial
Bone+Joint
CENTER

Patient Health History

Today's Date _____ **Referred By**_____

Patient Name_____ **DOB**_____ **Sex M F** **Age**_____

Employer _____ **Occupation** _____

Marital Status : Single Married Divorced Widow Separated

Past History Indicate Y (yes) or N (no)

_____ Heart Attack/Disease	_____ Anemia	_____ Pacemaker
_____ High Blood Pressure	_____ Hepatitis	_____ HIV/AIDS
_____ Ulcers/Heartburn	_____ Kidney Disease	_____ Diabetes
_____ Seizures/Epilepsy	_____ Stroke	_____ Cancer

_____ Other_____

Surgery/Operations	**Date**		
1. _____	____/____/____	3. _____	____/____/____
2. _____	____/____/____	4. _____	____/____/____

Accidents/Fractures	**Date**		
1. _____	____/____/____	3. _____	____/____/____
2. _____	____/____/____	4. _____	____/____/____

Allergies

Do you have any drug allergies? **Yes** **No**

1. _____ Reaction? (Hives, rash, swelling)_____
2. _____ Reaction? (Hives, rash, swelling)_____

Do you have any other allergies? (Food, Latex, etc) **Yes** **No**

_____ Reaction? (Hives, rash, swelling) _____
_____ Reaction? (Hives, rash, swelling)_____

Please list **ALL** medications you are you are currently taking and dosage, including non-prescription drugs:

Medication	**Dosage**	**Medication**	**Dosage**
1. _____	_____	5._____	_____
2. _____	_____	6._____	_____
3. _____	_____	7._____	_____
4. _____	_____	8._____	_____

Do you take Aspirin, Advil, Ibuprofen, Aleve, or Naprosyn? **YES** **NO**

Patient Name_____ **DOB**_____ **Date**_____

What is the reason for your visit today (describe symptoms and onset):_____

_____

Date Symptoms began_____

Acute injury(**New**) YES OR NO Chronic Symptoms (**Old**) YES OR NO

How did your symptoms begin?_____

On a scale of 1-10 (10 most severe) circle which best describes your pain: 1 2 3 4 5 6 7 8 9 10

Are your symptoms: **Constant** **Intermittent** **Worsening** **Improving**

Circle all that apply: **Pain** **Stiffness** **Instability** **Weakness** **Numbness/Tingling**

What makes symptoms worse?_____

What makes symptoms better?_____

What previous treatment have you had for this (Medications, therapy, surgery, injections)_____

_____

What previous treatment have been helpful? _____

PLEASE COMPLETE THE FOLLOWING ONLY IF THIS IS RELATED TO AN INJURY

Date of injury_____was this injury related to your employment? **YES OR NO**

Describe briefly how and where the injury occurred_____

_____

Are you currently working?_____Full or light duty_____

Are currently in physical therapy?_____ Where?_____

Social History

Do you use chewing tobacco or snuff? **Yes** or **No**

Do you drink alcoholic beverages? **Yes** or **No** Number of drinks per day_____ Week_____

Do you smoke (cigarettes/cigars/marijuana)? **Yes or No**

Date started_____/_____/_____ Quit_____/_____/_____

Do you exercise?_____ How often?_____

Do you play sports? **Yes or No** What sport?_____

Family History	**Age**	**Health**	**Age Deceased**	**Cause**
Spouse	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Children	_____	_____	_____	_____

Do you have any **blood relatives** who have had any of the following: (Please circle)

Diabetes (Sugar)	Heart Disease	Anesthetic Complications
Cancer	Abnormal Bleeding	Rheumatoid Arthritis

Review of Symptoms Please indicate any **personal** history below **PLEASE CIRCLE**

Constitutional Symptoms
Good general health
Recent Weight change

Eyes
Eye disease or injury
Wear glasses/contact lenses
Blurred or double vision

Ear/Nose/Mouth/Throat
Hearing loss/ringing
Earaches/drainage
Chronic sinus problems/rhinitis
Nose bleeds
Mouth sores
Bleeding gums
Sore throat/voice change
Swollen glands in neck

Cardiovascular
Heart trouble
Chest pain/angina pectoris
Palpitation
Shortness of breath
Wheezing

Breast
Breast pain
Breast lump
Breast discharge
Family history of breast Cancer
Take birth control pill
Previous breast surgery
Recent Mammogram

Genitourinary
Frequent urination
burning or painful urination
Excessive thirst or urination
Blood in urine
Incontinence or dribbling
Kidney stones

Psychiatric
Memory loss or confusion
Nervousness
Depression
Insomnia

Hematological/Lymphatic
Slow to heal after cuts
Anemia
Blood transfusion in the past
Enlarged glands

Skin
Rash/Itching
Change in skin color
Change in hair/nails
Non healing wound/injury
Mole changing/enlarging

Extremities
Varicose veins
Pain in calves/thigh/buttocks when walking
Blue toes or fingers
Blood clots or phlebitis

Endocrine
Glandular or hormone problem
Heat or cold intolerance
Dry Skin

Musculoskeletal
Joint pain
Joint swelling
Muscle weakness
Arthritis/Osteoarthritis
Bunions
Rheumatoid arthritis
Osteoporosis
Bone/Joint infections
Gout

Gastrointestinal
Loss of appetite
Change in bowel movements
Nausea/vomiting
Frequent diarrhea
Painful bowel movements/constipation
Rectal bleeding or blood in stool
Abdominal pain

Neurological
Frequent or recurrent headaches
Light headed or dizzy
Convulsions or seizure
Numbness/ringing sensations
Tremors
Paralysis
Head injury

THIS INFORMATION IS CORRECT AND ACCURATE TO THE BEST OF KNOWLEDGE

_____ _____

Patient/Guardian Signature **Date**

_____ _____

M.D. Review **Date**