

# PATIENT REGISTRATION FORM

MCKENZIE PHYSICIAN SERVICES, LLC

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M / F

Guarantor: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status (Circle one): Married / Single / Divorced / Widow / Partner / Other

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City/State/Zip)

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Okay to leave medical information on home voicemail?	Yes	No
Okay to leave medical information on cell voicemail?	Yes	No
Okay to leave medical information on work voicemail?	Yes	No

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

## Release of Information Consent

I authorize McKenzie Physician Services to discuss ANY information regarding my care with the below mentioned persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Contact Number: \_\_\_\_\_ Secondary Contact Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Contact Number: \_\_\_\_\_ Secondary Contact Number: \_\_\_\_\_

Do you have an Advanced Directive? Yes No

Do you have a Power of Attorney? Yes No

By signing below I am acknowledging the above information to be accurate. I understand that in order to revoke my consent to share my medical information with the above individuals, I need to do so in writing.

Name (Please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Revised 4/27/16

**1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

**2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

**3. NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

**4. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my care in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

**5. CONSENT TO PHOTO/VIDEO :**

Patient's  
Initials

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

**6. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

Yes  No I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

**7. EMAIL:**

Yes  No I hereby consent to provide my e-mail address, so that representatives from the Facility can e-mail information to me about health education or disease prevention and up-to-date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

**8. IMAGING SERVICES:**

Please check this box to allow the facility's Imaging Services to share your images with affiliated facilities, when requested, for continuing medical treatment.

**9. CELL PHONES:**

Yes  No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by emailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative			Date	Time	
Relationship to Patient		Interpreter, if Utilized	Date	Time	
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Physician Practice Authorization Form –  
Consent to Medical Treatment

**Medical History Questionnaire**  
Responses are Optional

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date of exam: \_\_\_\_\_

Reason for seeking medical attention: \_\_\_\_\_

I was referred to this office by: \_\_\_\_\_

Other doctors involved in my care: \_\_\_\_\_

**Personal Medical History:** Have you ever been diagnosed with the following? (Please circle)

**Cardiovascular:**

murmur  
angina/coronary disease  
congestive heart failure  
rheumatic fever  
bypass surgery  
valve replacement  
irregular heartbeat  
heart attack  
aneurysms \_\_\_\_\_  
type \_\_\_\_\_  
peripheral arterial disease  
cardiac disease  
stroke

**Infectious Disease:**

AIDS or HIV positive  
tuberculosis  
sexually transmitted disease  
MRSA infection

**Gynecological:**

endometriosis  
fibroids  
cysts  
irregular bleeding

**Musculoskeletal:**

rheumatoid arthritis  
osteoarthritis  
gout  
fibromyalgia

**Respiratory:**

emphysema/COPD  
asthma  
allergies/hayfever  
chronic bronchitis  
pneumonia  
asbestos exposure  
sleep apnea

**Gastrointestinal:**

ulcers  
polyps  
gallstones  
hiatal hernia  
hemorrhoids  
irritable bowel syndrome  
colitis  
diverticulosis  
gastrointestinal bleeding  
anal fistula  
anal fissure  
inflammatory bowel disease  
(Crohn's/ulcerative colitis)  
rectal prolapse

**Kidney/Bladder:**

stones  
prostate disorder  
incontinence  
infection  
kidney failure

**General:**

high blood pressure  
diabetes  
high cholesterol  
obesity  
migraines/headaches  
anemia  
thyroid problem  
seizure disorder  
paralysis  
glaucoma  
anxiety  
depression  
mental illness  
alcoholism/drug abuse  
blood transfusion if yes,  
when \_\_\_\_\_

Date	Hospitalizations/Operations Serious Illness or Injuries	Date	Hospitalizations/Operations Serious Illness or Injuries
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

**Present Medications:** (Include birth control pills and non-prescription items such as vitamins, aspirin, herbs, etc.)

Name	Dose	Times/ Day	Name	Dose	Times/Day
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

**Drug Allergies:**

Medication	Type of Reaction	Medication	Type of Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

## Medical History Questionnaire

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_ Former Regions of Residence: \_\_\_\_\_

Current Marital Status: S M W D Living Situation: Alone Roommate Spouse Parents  
(circle) (circle) Significant Other With Children

Do you wear a seat belt? Yes No  
Do you feel safe in your home? Yes No

**Preventative Health Status:**

Date of last physical exam: \_\_\_\_\_ Last eye exam: \_\_\_\_\_ Last dental exam: \_\_\_\_\_

Do you exercise regularly? Yes No Type: \_\_\_\_\_ How often? \_\_\_\_\_

Do you follow a special diet? Yes No Please describe: \_\_\_\_\_

Do you use tobacco? Yes No How much/how long? \_\_\_\_\_ Quit/When \_\_\_\_\_

Do you drink alcohol? Yes No How much per week? \_\_\_\_\_ Quit/When \_\_\_\_\_

Do you drink caffeine? Yes No How much per day? \_\_\_\_\_

Have you used illicit drugs? Yes No Which ones? \_\_\_\_\_ Quit/When \_\_\_\_\_

Last immunizations: (please give dates if known:)

Tetanus: \_\_\_\_\_ Pneumonia vaccine: \_\_\_\_\_ Flu vaccine: \_\_\_\_\_

TB skin test result: \_\_\_\_\_ Date: \_\_\_\_\_ Hepatitis B series: \_\_\_\_\_ Hepatitis A: \_\_\_\_\_

Have you ever had a blood transfusion? Yes No If yes, when? \_\_\_\_\_

Childhood illnesses: \_\_\_\_\_

Major injuries/date: \_\_\_\_\_

Have you ever had a colonoscopy? Yes No Last colonoscopy date \_\_\_\_\_

**FOR WOMEN ONLY:**

Date of last period: \_\_\_\_\_ Age periods began: \_\_\_\_\_ Last Pap: \_\_\_\_\_ History Abnormal Pap? Yes No

Last mammogram: \_\_\_\_\_ Birth Control Method: \_\_\_\_\_ Age at start of Menopause \_\_\_\_\_

Total number of pregnancies: \_\_\_\_\_ Miscarriages/Abortions: \_\_\_\_\_ Problems during pregnancies: \_\_\_\_\_

**FOR MEN ONLY:**

Last PSA or Prostate exam: \_\_\_\_\_

Family History:	Age if living	Age when deceased	Illness/cause of death
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Brothers/Sisters _____	_____	_____	_____
Children _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Immediate Family History** (circle all that apply)

cancer diabetes stroke high cholesterol aortic aneurysm bleeding or clotting disorder ulcers

trouble with anesthesia tuberculosis alcohol/substance abuse migraine headaches depression

asthma/allergies colon polyps high blood pressure arthritis/gout glaucoma heart disease

mental illness thyroid disease seizures/epilepsy kidney disease liver disease obesity

Inflammatory bowel disease (Crohn's/ulcerative colitis)

Other family medical history: \_\_\_\_\_

Reviewed by Provider: \_\_\_\_\_ Date: \_\_\_\_\_

## General and Vascular Surgery Medical History – Review of Systems

Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

REVIEW OF SYSTEMS: Check any of the following symptoms you have experienced WITHIN THE PAST YEAR

**GENERAL:**

- change in heat & cold tolerance
- persistent fever
- chills/cold intolerance
- excess appetite
- increased thirst
- lack of appetite
- night sweats
- swollen glands
- unusual weakness
- unusual fatigue
- unable to walk 2 flights of stairs
- weight change  
increase \_\_\_\_\_  
decrease \_\_\_\_\_
- Other \_\_\_\_\_
- None of the above

**ALLERGY:**

- sneezing
- environmental allergy
- food allergy \_\_\_\_\_
- Other \_\_\_\_\_
- None of the above

**SKIN:**

- ulcers
- bruise easily
- change in skin or mole
- dryness of skin
- rash or hives
- nail change
- unusual hair loss
- Other \_\_\_\_\_
- None of the above

**EYES:**

- eye pain
- blind spells (in one eye)
- change in vision
- contact lenses
- eye infection
- wear glasses
- Other \_\_\_\_\_
- None of the above

**EARS/NOSE/THROAT:**

- earache
- hearing loss
- ear infection or drainage
- ringing in ears
- bleeding gums
- hoarseness
- neck swelling/humps
- sores in mouth
- nose bleeds
- nasal polyps
- sinus trouble
- Other \_\_\_\_\_
- None of the above

**BREASTS:**

- discharge/bleeding
- nipple changes
- lump
- pain
- Other \_\_\_\_\_
- None of the above

**HEART:**

- white, blue or purple discoloration of hands or feet
- buttock, thigh, calf or foot pain when walking
- chest discomfort/pain
- irregular heart beat
- racing or fluttering heart
- swollen feet or ankles
- varicose veins
- family history of abdominal aortic aneurysm
- Other \_\_\_\_\_
- None of the above

**LUNGS:**

- shortness of breath
- persistent cough
- wheezing
- cough up blood
- cough up phlegm
- difficulty breathing
- None of the above

**GASTROINTESTINAL:**

- belching
- bloody or black stools
- change in caliber of stools
- constipation
- diarrhea
- difficult swallowing
- excessive gas
- food intolerance or pain when eating
- heartburn/esophageal reflux
- hemorrhoids
- incontinence of stool
- loose bowels/diarrhea
- nausea
- pain with bowel movements
- prolapse of tissue out of rectum
- recurrent abdominal pain
- vomiting
- Other \_\_\_\_\_
- None of the above

**URINARY:**

- change in urinary stream
- blood in urine
- difficulty urinating
- frequency
- leaking urine
- pain or burning on urination
- unusually large volumes or urine
- up at night to urinate?  
how often? \_\_\_\_\_
- incontinence
- sexual difficulty
- Other \_\_\_\_\_
- None of the above

**FEMALE:**

- heavy menstrual bleeding
- irregular menstrual periods
- discharge
- premenstrual symptoms
- prolapse of tissue out of vagina
- Other \_\_\_\_\_
- None of the above

**BONES AND JOINTS:**

- back or neck pain
- cramps in muscles
- painful or stiff joints
- pain down backs of legs
- pain in legs with walking
- swelling in legs
- redness of joints
- Other \_\_\_\_\_
- None of the above

**MOOD/MENTAL HEALTH:**

- depressed or sad
  - irritable or angry
  - anxious, tense, or worried
  - fearful
  - sleep problems
  - loss of interest in activities
  - fatigue
  - compulsive behaviors
  - concentration/memory problems
  - marital, family or work problems
  - stress
  - Other \_\_\_\_\_
  - None of the above
- NEUROLOGIC:**
- coordination problems
  - difficulties in speaking
  - dizziness
  - fainting spells
  - frequent headaches
  - loss of balance
  - loss of sensation
  - muscle weakness
  - numbness or tingling
  - Other \_\_\_\_\_
  - None of the above

Reviewed by \_\_\_\_\_

Date \_\_\_\_\_