ProHEALTH Care

Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date:

Thank you for selecting ProHEALTH Care Associates.

PATIENT INFORMATION

Patient's Last Name: | First: | Middle: | Gender: | Age: | Birth Date:

Marital Status: S M D W SEP | Preferred Language: | Student: ☐ Part Time ☐ Full Time

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Street Address: | Apt # | City/Town: | State: | Zip Code: | Home Phone No.:

Mobile Phone No.: | Email Address: | Work No.:

Name of Employer: | Address: | City/Town: | State: | Zip Code:

SPOUSE'S INFORMATION

Last Name: | First: | Middle: | Gender: | Age: | Birth Date:

Mobile Phone No.: | Work No.:

Employer: | Street Address: | City/Town: | State: | Zip Code:

PARENT INFORMATION

Complete the section below with your parent's information if you are a full time student covered under their health insurance.

Insured's Last Name: | Insured's First: | Middle: | Gender: | Age: | Birth Date:

Mobile Phone No.: | Work No.:

Employer: | Street Address: | City/Town: | State: | Zip Code:

EMERGENCY CONTACT

Name: | Relationship to Patient:

Primary Telephone No.: | Secondary Telephone No.:

PRIMARY CARE PHYSICIAN

Primary Care Physician Name:

Street Address:

City, State, Zip: | Telephone No.:

REFERRING PHYSICIAN

Referring Physician (if not same as PCP):

Street Address:

City, State, Zip: | Telephone No.:

Please provide the name/s and telephone numbers of any other doctors treating you at this time.

PHARMACY INFORMATION

Name of Pharmacy: | Address: | Telephone No.: | Fax No.:

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Name: | Claims Address: | Telephone No.: | Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above): | Birth Date:

SECONDARY INSURANCE

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Name: | Claims Address: | Telephone No.: | Group No.:

ID No.:

Insured's Name (if not self, spouse or parent listed above): | Birth Date:

WORKER'S COMPENSATION INFORMATION

Is the reason for this visit due to a work related accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Injury/Onset of Illness: | Employers Insurance Carrier Name & Address:

WCB Case No.: | Carrier Case No.:

Are you currently working? ☐ Yes ☐ No | Last Day Worked:

Briefly describe how and where patient's injury occurred:

NO FAULT INFORMATION

Is the reason for this visit due to a motor vehicle accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Accident: | Insurance Carrier Name: | Address:

Policyholder's Name: | Policy No.: | Claim No.:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Other: | Claims Adjuster: | Telephone No.:

Are you currently working? ☐ Yes ☐ No | Last Day Worked:

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION

Law Firm Name: | Address: | Name of Attorney Handling Case: | Telephone No.:

Fax No.:

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

ProHEALTH Care Associates, LLP

GENERAL CONSENT

Consent for Medical Treatment. I give consent to **ProHEALTH Care Associates, LLP**, its staff, physicians and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the Practice for my health and well-being.

Authorization of Payment of Insurance Benefits. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

Signature on File (applies to Medicare patients only). I certify that the information given by me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Financial Agreement. I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer at the time of service, HMO or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I agree to pay all bills when presented. I understand that there will be a $25.00 charge for all returned checks.

Release of Information. I understand that the Practice will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice's charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of the Practice or a third party payor; (5) for the Practice's normal health care operations. I understand that the Practice may communicate information including protected health information with me through text or email, and through the Practice's electronic health record system.

I understand that to ensure continuity of care, all ProHEALTH providers will have access to the information in my electronic health record.

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

I understand that the Practice may access information from any pharmacy from which I have filled prescriptions. This includes prescriptions for medicines to treat AIDS/HIV, mental health illness, substance abuse, and STDs, if applicable. I further understand that this information will become a permanent part of my medical record.

Acknowledgement of Receipt of the Privacy Notice. I have received a copy of the Practice's Privacy Notice, and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this General Consent form.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

IF SIGNED BY A LEGAL REPRESENTATIVE (PRINT NAME) RELATIONSHIP TO PATIENT

IMPORTANT NOTICE

In order to address changes in the Federal law, ProHEALTH has revised its HIPAA Privacy Notice and General Consent form to address issues such as messages on answering machines, discussions with your family and friends, and email transmissions of your patient information. You may obtain a copy of the revised Privacy Notice from the front desk staff. Please review these documents closely and let us know if you have any questions.

ANY PREVIOUS RESTRICTIONS REGARDING YOUR INFORMATION THAT YOU MAY HAVE MADE WILL NO LONGER BE VALID. If you wish to request any restrictions on ProHEALTH's use or disclosure of your information, you must make your request in writing to the practice manager. We will let you know within fourteen (14) days whether or not we can accept the restriction. If we are able to accept the restriction, it will go into effect as soon as we notify you.

We take the confidentiality of your information very seriously and strive to ensure appropriate safeguards are in place at all times.

Please sign below to acknowledge that you have received this form and understand its contents.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

IF SIGNED BY A LEGAL REPRESENTATIVE (PRINT NAME) RELATIONSHIP TO PATIENT

ORTHOPEDIC/PODIATRY HISTORY

Name: _____ Date of Birth _____

☐ Male ☐ Female ☐ Right-handed ☐ Left-handed

Occupation _____

When did the problem start _____

Is your present complaint due to an injury sustained while at work? ☐ Yes ☐ No

Is your present complaint due to a motor vehicle accident? ☐ Yes ☐ No

Please describe the problem that brought you here _____

Which side of the body is injured: ☐ Right ☐ Left ☐ Both

If unable to work, please give dates: from: _____ to _____

Type of pain ☐ Dull ☐ Sharp ☐ Burning ☐ Constant ☐ Radiating

Have you experienced (check all that apply) ☐ Clicking ☐ Swelling ☐ Locking
☐ Buckling ☐ Stiffness ☐ Weakness ☐ Difficulty using stairs

Any numbness or tingling _____

Does the pain wake you at night _____

What makes it better _____

Does the pain radiate to any other location? ☐ Yes ☐ No Where? _____

Rate your pain from 1 -10 (10 being the most severe) _____

Have you had any problem with this part of the body in the past? ☐ Yes ☐ No

Explain _____

Are you taking any medication for this problem _____

Describe any treatment thus far _____

Have you consulted any other physicians for this problem? ☐ Yes ☐ No

If yes, who? _____

ORTHOPEDIC/PODIATRY HISTORY

PLEASE CHECK ANY CONDITIONS THAT YOU HAVE CURRENTLY OR HAVE HAD IN THE PAST:

- ☐ Anemia (bleeding disorder)
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur/Palpitations
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Lyme Disease
- ☐ Currently Pregnant
- ☐ Mental Disorder
- ☐ Phlebitis
- ☐ Rheumatoid Arthritis
- ☐ Seizures or Epilepsy
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcer
- ☐ Venereal Disease

Please list other medical problems_____

PRIMARY CARE PHYSICIAN:

_____

Date Last Seen: _____

FAMILY HISTORY:

Does anyone in your immediate family suffer from any of the conditions listed above? ☐ Yes ☐ No

If so, what_____

PLEASE LIST ALL MEDICATIONS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you take aspirin on a daily basis: ☐ Yes ☐ No Do you have any metal in body ☐ Yes ☐ No

PAST SURGERIES/HOSPITALIZATIONS: ☐ Yes ☐ No Which Hospital_____

List Surgery and Year_____

List ANY allergies_____

Do you smoke: ☐ Yes ☐ No How many years_____ If quit, when_____ pks daily_____

Do you drink alcohol? ☐ Yes ☐ No If so, how much_____

If yes, how much: ☐ Rarely ☐ Socially ☐ 1 drink a day ☐ 2-3 drinks a day ☐ 4 drinks or more a day

Are you currently working ☐ Yes ☐ No If not, when did you last work_____

Patient/Parent or Guardian Signature _____ Date_____

MD Signature _____ Date_____