Thompson Outpatient Clinic
REGISTRATION

Patient Information:

_____ /____/_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Mailing Address) (City, State, Zip) (Home phone)

_____

(Cell phone) (Email address)

SINGLE MARRIED DIVORCED WIDOWED MALE/FEMALE

EMPLOYED P/T STUDENT F/T STUDENT OTHER

Employment Information:

_____

(Occupation) (Employer)

_____

(Address) (City, State, Zip) (Work phone)

Spouse Information:

_____ /____/_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Employer) (Work Phone Number)

Responsible Person (If Applicable):

_____ /____/_____

(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____

(Address) (City, State, Zip) (Home phone)

_____

(Employer & Phone Number) (Relationship to Patient)

Emergency Contact (Someone Not Living in home of Patient)

_____

(Name) (Phone Number) (Relationship to Patient)

_____

(Address) (City, State, Zip Code)

Insurance Information: Primary Insurance:

_____ /____/_____

(Name of Insured) (Date of Birth) (Relationship to Patient)

_____

(Insurance Company) (Group Number) (ID Number)

Secondary Insurance:

_____ /____/_____

(Name of Insured) (Date of Birth) (Relationship to Patient)

_____

(Insurance Company) (Group Number) (ID Number)

How were you referred to our office? **Attorney Doctor Patient** (Name of source) _____

Is your illness or injury related to any of the following: **Employment Emergency Accident Auto Accident**

If auto accident please print state where accident occured. _____

Notice of Privacy Receipt:

I acknowledge that I was provided with the Notice of Privacy Practices of Thompson Outpatient Clinic.

Print Name of Patient:_____ Patient Date of Birth:_____/_____/_____

Signature of Patient:_____

(For Patient Representative if applicable)

Printed Name of Personal Representative:_____ Relationship:_____

Signature of Personal Representative:_____

Date:_____/_____/_____

SPECIFIC CONSENT FOR RELEASE OF PATIENT INFORMATION:

_____(Responsible person if minor), understand that I am giving consent of release of the approved information listed below for the duration of one year to the following person/persons:

_____

(Name) (Relationship to Patient)

_____

(Name) (Relationship to Patient)

_____

(Name) (Relationship to Patient)

_____I authorize the release of any test results. _____(Patient Initials)

_____I authorize the discussion of symptoms or complaints with medical staff. _____(Patient Initials)

_____I authorize the release of medical information along with directions and instructions. _____(Patient Initials)

_____I authorize the use of any home answering machine for any medical information and correspondence in reference to my medical records. _____(Patient Initials)

Release of Medical Record Information:

_____(initial) I understand that I may only request medical records that are generated through the practice of Thompson Outpatient Clinic. I understand records brought to the clinic from another doctor will not be released to me.

Consent to Treatment:

_____(Patient Initials/Responsible Person if Minor) I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment.

Financial Responsibility and Assignment of Benefits:

_____(Patient Initials/Responsible Person if Minor) I agree to pay all charges for medical and health care services not covered by my insurance company.

I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

_____/____/_____

(Signature of Patient or Other Legally Authorized Person) **(Date)**

_____/____/_____

(Signature of Witness-Clinic Employee) **(Date)**

History & Physical

Social History

Do you drive? No ☐ Yes ☐

Do you use Tobacco products? No ☐ Yes ☐

If yes, Type/ Amount/ How long?_____

Do you drink Alcohol? No ☐ Yes ☐

If yes, Type/ Amount/ How long?_____

Do you use illegal drugs? No ☐ Yes ☐

If yes, Type/ Amount/ How long?_____

Do you sleep well at night? No ☐ Yes ☐

Do you exercise? No ☐ Yes ☐

Do you drink coffee? No ☐ Yes ☐

When was the last year of Tetanus Shot?_____

Have you ever been exposed/infected with:

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently or have you ever had any problems in the following areas:

	NO	YES		NO	YES
Fever, weight loss/gain	☐	☐	Allergies/Hay fever	☐	☐
Skin	☐	☐	Sinus Congestion	☐	☐
Headaches	☐	☐	Post Nasal Drip	☐	☐
Migraines	☐	☐	Chronic Cough	☐	☐
Seizures	☐	☐	Dry Throat/ Mouth	☐	☐
Constipation	☐	☐	Asthma	☐	☐
Diarrhea	☐	☐	Emphysema	☐	☐
Thyroid/ Other Glands	☐	☐	Chronic Bronchitis	☐	☐
Genital/Kidney/Bladder	☐	☐	Diabetes	☐	☐
Anemia	☐	☐	Hypertension	☐	☐
Bleeding Problems	☐	☐	Chest Pain	☐	☐
Allergies/Immunities	☐	☐	Rheumatoid Arthritis	☐	☐
Psychiatric	☐	☐	Muscle/Joint Pain	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

History & Physical

Please fill out this form entirely, to the best of your knowledge.

Last Name:_____ First Name:_____ Middle:_____
Occupation:_____ SS#:_____ Age:____ DOB_____
Last Primary Care Doctor:_____
Phone:_____
Last Visit Date:_____
If you see any specialists, please list them here:

_____

_____

Surgeries, Illnesses & Injuries

Please indicate any surgeries and include any not listed.

NONE		Hysterectomy	____/____/____ Complete or Partial (circle)
Bypass	____/____/____	C-Section	____/____/____
Stents	____/____/____	Joint/Hip	____/____/____
Valve Replace	____/____/____	Appendix	____/____/____
Gallbladder	____/____/____	Hernia	____/____/____
Tonsillectomy	____/____/____		
Other	____/____/____	_____	
Other	____/____/____	_____	

Please list any injuries or illnesses that may or may not have required a hospital stay with dates.

_____

_____

Family History

Please note ANY family history (parents, grandparents, siblings, children; Living or Deceased) for the following conditions

Disease Condition:	No	Yes	?	Relationship to You / Onset Date
Tuberculosis	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Aids/HIV	☐	☐	☐	_____
Mental Illness	☐	☐	☐	_____
Asthma or Lung	☐	☐	☐	_____

History & Physical

Preventative Screening

Please indicate the last date any of these tests were performed:

Bone Density Screening	___/___/___
Cardiac Stress Test	___/___/___
Chest X-Ray	___/___/___
EKG	___/___/___
Colonoscopy	___/___/___
Mammogram	___/___/___
PSA Screen	___/___/___
Well Woman Exam	___/___/___

Do you have any active Advanced Directives? If so, please bring in a copy so we can add it to your chart.

Do you use any Medical Devices? Please circle if applicable:

Bathtub Rails	Brace	Dentures	Pacemaker	Treadmill
Glucose Monitor	Cane	Stationary Bicycle	Walker	Oxygen
Blood Pressure Cuff	Crutches	Glasses or Contacts	Support Stockings	Wheelchair
Knee Replacement-	Left	Right	Both	
Hearing Aid-	Left	Right	Both	
Hip Replacement-	Left	Right	Both	

Patient Signature:_____ Date:___/___/___

If Minor:

Guardian Signature/Relationship:_____ Date:___/___/___

Telemedicine Consent Form
Thompson Outpatient Clinic, LLC

1. **Introduction:** Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

2. **Consent for Treatment:** I voluntarily request Thompson Outpatient Clinic, technical assistants and other health care providers they may deem necessary to participate in my medical care through the use of telemedicine. I understand that Thompson Outpatient Clinic providers may practice in a different location than where I present for medical care, may not have the opportunity to perform an in=person physical examination, and rely on information provided by me. I acknowledge that Thompson Outpatient Clinic advice, recommendations, and/or decision may be based of factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an extract science and that no warranties or guarantees are made to me as to result or cure.
   If Thompson Outpatient Clinic providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a due to a technical problem or equipment failure, alternative means o communication may be implemented or an in-person telemedicine session, I should alert my treating provider. (in the case of emergencies dial 911 or go to the nearest hospital emergency department.)

3. **Release of Information:** To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to alternative providers. I understand and agree that the information I am authorizing to be released may include: AIDS/HJIV test results, diagnosis, treatment and related information, drug screen test results and information about drug and alcohol use and treatment, mental health information and genetic information.
   I understand that the disclosure of my medical information by providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of the information by preventing unauthorized review, I understand that electronic transmission of data and video images, and audio is new and developing technology and that the confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

   I certify that this form has been fully explained to me, that I have read it or have had it read to me and that I understand it's contents.

Printed Name: _____

Signature: _____

Date: _____