Optimal Care & Wellness

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS	
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or if minor signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME/CELL PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:

❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL

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PATIENT MEDICAL HISTORY

PATIENT NAME (LAST-FIRST-MIDDLE INITIAL)

Consent to call: Yes / No Consent to Text: Yes / No Portal Access: Yes / No

Cell Phone: Email Address:

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: **DATE:**

PREFERRED PHARMACY:

Allergies & Reaction

☐ No Known Allergies	☐ Adhesive Tape _____	☐ Latex _____	☐ Morphine _____
☐ Iodine/Shellfish/Contrast Dye _____	☐ Sulfa Drugs _____	☐ Aspirin _____	☐ Codeine _____
	☐ Anesthesia _____	☐ Penicillin _____	☐ Other _____

FAMILY HISTORY-Please indicate if your mother, father or siblings have had any of the following.

Arthritis		Hypertension	
Cancer/Type		Hyperlipidemia	
Diabetes		Stroke	
Heart Problems		Thyroid Disorder	

Social History

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Infrequently ☐ Recovering Alcoholic

Do you use tobacco? ☐ Never ☐ Smoking (_____packs per day) ☐ Vape ☐ Chew ☐ Quit (How long?) _____

Do you use illicit or recreational drugs? ☐ Never ☐ Marijuana ☐ Other_____

Surgical History: Have you had any of the following Surgeries? If yes, please indicate year

☐ Adenoids _____	☐ CABG _____	☐ Hip _____	☐ Tonsillectomy _____
☐ Amputation _____	☐ Cancer _____	☐ Hysterectomy _____	☐ Tubal Ligation _____
☐ Angioplasty _____	☐ Cataract _____	☐ Knee _____	☐ Vasectomy _____
☐ Appendectomy _____	☐ Cholecystectomy _____	☐ Mastectomy _____	☐ Other: _____
☐ Back _____	☐ Gastric Bypass _____	☐ Neck _____	☐ Other: _____
☐ Breast Biopsy _____	☐ Hernia repair _____	☐ Prostate _____	☐ Other: _____
☐ Breast Lumpectomy _____	☐ Hemorrhoidectomy _____	☐ Thyroidectomy _____	☐ Other: _____

Medical History: Have you had any of the following?

☐ ADD/ADHD	☐ Bladder Problem	☐ Difficulty Swallowing	☐ Hepatitis	☐ Obesity
☐ AIDS/HIV	☐ Blood Diseases	☐ Diverticulitis	☐ High Cholesterol	☐ Ovarian Cancer
☐ Abdominal Pain	☐ Blood Transfusions	☐ Ear Problems	☐ Hospitalization	☐ Parkinson's
☐ Abnormal Bleeding	☐ Breast Cancer	☐ Eating Disorder	☐ Hypertension	☐ Polyps
☐ Abnormal Pap Smear	☐ Breast Problems	☐ Eczema	☐ Hypothyroid	☐ Pre-Eclampsia
☐ Abuse/Domestic Violence	☐ COPD	☐ Edema	☐ Incontinence	☐ Pulmonary Embolism
☐ Acid Reflux (GERD)	☐ Cancer	☐ Emphysema	☐ Infertility	☐ Seizure/Epilepsy
☐ Allergies/Hay fever	☐ Chicken Pox	☐ Endometriosis	☐ Kidney Disease	☐ Skin Problem
☐ Anemia	☐ Chronic Ear infection	☐ Fibromyalgia	☐ Kidney Stones	☐ Stroke
☐ Anesthesia Complication	☐ CHF	☐ GI Problems	☐ Liver Disease	☐ Thyroid Disorder
☐ Anxiety	☐ Constipation	☐ Gout	☐ Lung Disease	☐ Thyroid Nodule
☐ Arthritis	☐ Coronary Artery Disease	☐ Headache	☐ MRSA	☐ Tuberculosis
☐ Asthma	☐ Deep Vein Thrombosis	☐ Hearing loss	☐ Meniere's	☐ UTIs
☐ Autism	☐ Dementia	☐ Heart Attack	☐ Mental Disorder	☐ Varicosities
☐ Back Problems	☐ Depression	☐ Heart Disease	☐ Mental Illness	☐ _____
☐ Bedwetting	☐ Developmental Disorder	☐ Heart Problem	☐ Muscle Problem	☐ _____
☐ Birth Defects	☐ Diabetes		☐ Nervous System Disorder	

Medications: List any medication you are currently taking (to include any over the counter medications, vitamins, & herbal supplements).

Medication	Dosage	Frequency