NEW PATIENT DEMOGRAPHICS

PATIENT INFORMATION	
Full name:	
Date of birth:	
Age/ Sex:	
Social Security No:	
e-mail address:	
Address:	
City:	
State/ Zip Code:	
Home phone:	
Cell phone:	
Work phone:	
Marital Status:	
Race (optional):	
Preferred language:	
Emergency notification contact:	
Emergency notification phone:	
Relationship of emergency contact:	
Preferred pharmacy:	

INSURANCE INFORMATION	
PRIMARY:	SECONADARY:
Member number/ID:	Member number/ID:
Group name/number:	Group name/number:
Address:	Address:

Patient name: DOB:

NEW PATIENT HEALTH HISTORY

MEDICATIONS AND SUPPLEMENTS *(Attach sheet if necessary)*			
Name	Dose	Times per day	Prescriber

ALLERGIES	
Medication	Reaction

HEALTH MAINTENANCE SCREENING			
	Date	Result	Facility/Provider
Colonoscopy			
Pap smear			
Mammogram			
Bone density			
PSA			
CT chest			
HIV screen			
Hepatitis C screen			
Abdominal ultrasound			
Last physical			

Patient name: DOB:

VACCINATIONS	
	Date
Flu vaccine:	
Pneumovax:	
Prevnar13:	
TdaP (*Tetanus*):	
Shingrix/Zostavax (*Shingles*):	
HPV:	
Covid-19:	

SURGERIES		
Type *(specify side)*	Date	Facility/Provider

WOMEN'S HEALTH HISTORY	
Age of first menstruation:	
Date of last menstrual cycle:	
Number of pregnancies:	
Number of live births:	
Pregnancy complications:	
Age of menopause onset:	
History of abnormal PAPs? *(if yes, state date & results)*	

Patient name: DOB:

PERSONAL MEDICAL HISTORY *(current and past)*	
Disease/Condition	Comments

FAMILY HISTORY	Father	Mother	Siblings	Other
Living?	☐	☐	☐	☐
Bleeding/clotting	☐	☐	☐	☐
Colon/bowel problems	☐	☐	☐	☐
Cancer/type	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Drug/alcohol addiction	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Other:				

SOCIAL HISTORY	
Occupation *(past/present)*:	
Retired/unemployed/disabled:	
Highest degree/years of education:	
Marital status:	
Children *(if yes, how many?)*:	
TOBACCO USE *(if applicable)*	
Smoke cigarettes?	
Packs/day:	
# of years:	
If quit, state quite date, packs/day, and # of years:	
Other forms of tobacco used:	
ALCOHOL USE *(if applicable)*	
Type of alcohol:	
# of drinks/week:	
DRUG USE *(if applicable)*	
Use or used marijuana or recreational drugs?	
Use or used needles to inject drugs?	
SEXUAL HISTORY	
Sexually involved currently?	
Gender of sexual partner(s):	
Birth control method:	
EXERCISE	
Do you exercise regularly?	
If yes, what kind of exercise/for how long/how often?	

DIET	
How would you rate your diet? (Good/fair/poor)	
Do you drink coffee/eat/soda? (if yes, how many cups/day?)	
SAFETY	
Do you use seat belts consistently?	
Do you feel safe at home?	
Do you have an advanced directive/living will?	

OTHER PROVIDERS/SPECIALISTS		
	Name	Last visit
Cardiology		
Gastroenterology		
OB/GYN		
Neurology		
Pulmonology		
Nephrology		
Other:		

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

I. PRIVACY ACKNOWLEDGEMENT

a. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? □ **YES** □ **NO**
If no, is there another number at which we may try to reach you? _____

b. May we mail to the address you provided information regarding your appointment/test results? □ **YES** □ **NO**
If no, is there another address at which we may send you information? _____

c. Do you wish us to share health information regarding you with a family member or friend? □ **YES** □ **NO**
If yes, please provide names of people. _____

d. May we contact you via email with information regarding our practice, educational programs, and general health information? □ **YES** □ **NO**
If yes, I understand that email transmissions may not be secure and will not be used for communicating my personal health information.

e. NOTE: To protect your information, we reserve the right to use professional judgment and discretion when communicating information/test results which may be "sensitive".

II. REFERRALS FOR SERVICES

a. If you are up to 15 minutes late, your provider may not be able to see you.

b. Failure to keep 3 scheduled appointments without giving notice may result in your discharge from the clinic. Failure to keep 5 scheduled appointments, even with advance notice, may result in your discharge from the clinic.

III. CONSENT TO TREAT

a. I authorize Onalaska Wellness and Aesthetics to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the clinic and I consent to care by

such providers. I understand that these services are voluntary and that I have the right to refuse these services.

b. I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is an accidental blood borne pathogen exposure to any medical, nursing or other clinical staff, in order to test such blood for the presence of Hepatitis B virus, Hepatitis C virus, or HIV. I understand and agree that the result of such lab tests shall be maintained confidential, except to my treating healthcare workers, any clinical staff exposed, and as may be allowed by any applicable state or federal statute, regulation, or rule of law. This means that if any medical practice worker or physicians are exposed to my blood through needle stick, blood splash, or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV and/or hepatitis. The result will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed, or as required by law.

IV. FINANCIAL AGREEMENT

a. Patient and/or guarantor is responsible for any charges incurred. Any charges shall be on the prevailing rate for the specific services rendered or items provided, that is in the charge master on the date the services are rendered/items provided. It is a courtesy of our office to file your insurance. You are responsible for your co-pay and percentage which the insurance company is not liable for on the day of your visit. If we are unable to obtain payment within a reasonable amount of time from patient and/or guarantor, we will place your account with a collection agency, and you agree to be responsible for additional expenses incurred including and not limited to court costs and attorney fees if legal action is necessary of collections.

b. I (patient) authorize contact for purposes of financial matters and account collection through any telephone number provided. Patient/guarantor agrees to permit Onalaska Wellness and Aesthetics or its agents to review financial ratings and credit reports when necessary. I have read and fully understand the above statement of payment policy. I request any benefits on my behalf be

paid to this medical practice. I authorize the release of any information acquired in the course of my treatment to my insurance company or any third party obligated to pay all or part of my medical bill as needed to issue benefits.

c. To insure accuracy, photo ID is required. Without photo ID, we require your photograph. I certify that all identification information is correct and true. I understand that providing false information is a crime and may be reported to local law enforcement.

V. CONSENT TO PHOTOGRAPH

a. I understand that photos, videos, and other images may be made/recorded to document my care. I understand the medical practice will retain ownership of these images/recording but that I will be allowed to view them and obtain copies. I understand that these images will be stored securely to protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used only upon written authorization from me or my legal representative.

VI. MEDICARE AND MEDICAID INFORMATION

a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical/other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare/Medicaid claim. I certify that I have provided any required information concerning any other liability for medical practices in order to complete the Medicare Secondary Payor (MSP) form. I request that payment of authorized benefits be made on my behalf.

b. I authorize Onalaska Wellness and Aesthetics to secure information from the Department of Human Services regarding my qualification for Medicaid.

VII. CONSENT FOR ELECTRONIC PRESCRIBING

a. I understand that medical practices and offices use electronic prescription systems which allow prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using e-prescribing systems 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.

VIII. PATIENT PORTAL

a. I consent to participation in the facility patient portal and understand that my personal health and individually identifying information is made available to me in the portal.
b. I understand the use of the portal is for non-emergency purposes.
c. I understand that there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
d. I understand that my email address is required to initiate portal access, and will be used for communications related to the portal. I agree to communicate my e-mail address changes.
e. I have read and understand the Terms and Conditions of Use. I understand that my access to the portal requires my acceptance of the Terms and Conditions of Use.
f. **Check here if you refuse access to portal** ☐

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

IX. OFFICE POLICIES: Please read carefully

a. **Missed appointments**
- Cancellation policy: 24 hr notice required
- No show fee: $40

b. **Meds not prescribed**
- Controlled substances: e.g., *Vicodin*
- Sleep medications: e.g., *Ambien*
- Anxiolytics: e.g., *Xanax*

c. **After hours calls with physician**
- If call results in a specific treatment decision, charge will be applied to your account depending on time spent: $50 (up to 15 min), $100 (15+ min)

d. **Walk-ins**
- Please call front desk and inquire about a same day appointment. Walk-ins are welcome and will bee seen as the schedule permits.

e. **Late arrival**
- If arriving more than 15 minutes late, please notify us. Otherwise, you will be rescheduled.

f. **Med refills**
- Call your pharmacy prior to calling our office.
- Messages left after hours for refills will be addressed when office reopens. If urgent, you must discuss with staff or physician.

g. **Payment due prior to seeing physician**
- Return check fee: $35

h. **Routine visits**
- Sessions are allotted 15 min. If multiple issues need to be addressed, you may be asked to return for another appointment.

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

i. **Forms**

- Detailed forms brought to the physician to be completed will require a scheduled appointment.
- Medical clearance letters need at least 2 weeks' notice and will require a scheduled visit.

BY SIGNING AND DATING THIS SPACE, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT

Patient/Authorized Representative Signature:

_**X**_____ Date: _____ Time: _____

If person other than patient is responsible for payment:

Guarantor Signature:

_**X**_____ Date: _____ Time: _____

Witness Signature:

_**X**_____ Date: _____ Time: _____

REGISTRATION CONSENTS AND ACKNOWLEDGEMENTS

RELEASE OF INFORMATION FORM

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name | Date of Birth | Medical Record Number

Address | City | State | Zip | Telephone Number | Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information

Agency or Individual(s) Authorized to Receive my Health Information

Address | City | State | Zip | Telephone Number

Health Information that may be used / disclosed is limited to the following:
- ○ Discharge Summary
- ○ History & Physical
- ○ Consultation(s)
- ○ Progress Notes
- ○ Lab
- ○ Emergency Room Record
- ○ Pathology Report
- ○ Operative Note(s)
- ○ Imaging/X-Ray
- ○ X-Ray Reports
- ○ Entire Record
- ○ Other *(specify)* _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____

From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):
- ○ Treatment/Consultation
- ○ At Request of Patient
- ○ Research
- ○ Marketing
- ○ Billing or Claims Payment
- ○ At Request of Employer
- ○ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

○ **Yes** ○ **No** If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	
Witness's Signature	Date	Time	Expiration Date or Event

○ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*

○ Electronic copy requested.