REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: _____
(First) (Last)

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female
(Month) (Day) (Year)

Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

Home #: _____ Cell #: _____

E-mail: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed

Race/Ethnicity: ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other: _____

Contact Method: ☐ Home ☐ Mobile ☐ E-mail Language: ☐ English ☐ Spanish ☐ Other: _____

Employer Name: _____

Employer Address: _____
(Street Address) (Apartment Number) (City) (State) (Zip Code)

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____/_____/_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

SECONDARY INSURANCE (If Applicable)

Insurance Name: _____

ID #: _____

Policy Holder's Name: _____

D.O.B: _____/_____/_____
(Month) (Day) (Year)

Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

PHARMACY

Pharmacy Name: _____ Phone #: _____

Address: _____

New Patient Medical History

PLEASE BRIEFLY STATE IN THE BOX BELOW THE REASON FOR YOUR VISIT

PAST MEDICAL HISTORY

Condition / Disease	Year Began
☐ Menstrual Period (**Female Patients)**	
☐ # Of Pregnancies (Birth / Miscarriages) **(Female Patients)**:	
☐ Hypertension	
☐ High Cholesterol	
☐ Hyper / Hypothyroidism	
☐ COPD, Emphysema, or Asthma	
☐ Diabetes	
☐ GERD	
☐ Depression or Anxiety	
☐ ADD or ADHD	
☐ Heart Conditions	
☐ History of Covid-19	

PAST SURGICAL PROCEDURES/HOSPITALIZATIONS/SERIOUS INJURIES

Operation / Hospitalization / Injury	Month / Year

FAMILY HISTORY

Relative	**Living / Deceased**	**Current age or Age at Death**	**Cause of Death**	**Health Problems**
Father:				
Mother:				
Brother(s):				
Sister(s):				
Children(s):				

MEDICATION / FOOD ALLERGIES OR INTOLERANCES
LIST BELOW MEDICATIONS OR FOODS CAUSING AN ALLERGIC REACTION (I.E., RASH, SWELLING) OR INTOLERANCE (I.E., NAUSEA)

Medication / Food	Reaction

CURRENT MEDICATIONS

Medication Name	Dosage

VACCINATIONS

	Date (Month / Year)
COVID-19	
Tetanus (Tdap)	
Influenza	
Pneumovax (Pneumonia)	
Zostavax (Shingles)	

HEALTH MAINTENANCE

Test Performed	Date (Month / Year)	Please Check Yes or No
Last Blood Work		Abnormal? ☐ Yes ☐ No
Lipid (Cholesterol)		Abnormal? ☐ Yes ☐ No
Colonoscopy		Abnormal? ☐ Yes ☐ No
Mammography **(Female Patients)**		Abnormal? ☐ Yes ☐ No
Pap Smear **(Female Patients)**		Abnormal? ☐ Yes ☐ No
PSA/Prostate **(Male Patients)**		Abnormal? ☐ Yes ☐ No
Bone Density		Abnormal? ☐ Yes ☐ No
Eye Exam		
Hbg A1C (Diabetes)		

SOCIAL HISTORY

Do you drink alcohol?	☐ Yes	☐ No	Number of drinks?
Do you currently smoke?	☐ Yes	☐ No	If yes, how many packs per day?
Are you a former smoker?	☐ Yes	☐ No	If yes, what year did you quit?
Do you exercise?	☐ Yes	☐ No	Duration and Frequency?
Do you drink caffeine?	☐ Yes	☐ No	If yes, how many cup per day?

CONSENT TO TREATMENT

I hereby request and consent to diagnostic, therapeutic procedures and medical treatment by **Apex Mobile Wellness** as determined necessary in the professional medical judgment of my treating physician, including but not limited to electrocardiograms, blood tests, and administration of medications and vaccinations and obtaining e-script history, as applicable. I am aware that the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantee as to the outcome of any procedures, treatments or examinations have been made to me.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION TO SECOND PARTY

By signing below, I hereby give permission to **Apex Mobile Wellness** to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____ Phone #: _____

Name of Individual _____ Relationship to patient _____ Phone #: _____

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-pays, any services that is not covered by your insurance plan, and any service that your insurance company has determined not be "medically necessary".

I have read and understand this information. I understand that my insurance company may deny coverage and request that **Apex Mobile Wellness** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services. Without requiring payment at the time of service based on such reliance.

X_____

Signature of Patient (or patient's parent or guardian) Print Name Date

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I authorize insurance payments to be made directly to **Apex Mobile Wellness** for services rendered. I understand that I am responsible for any and all balances not covered by my insurance carrier.

I hereby authorize **Apex Mobile Wellness** to release medical or incidental information that may be necessary for medical care or processing of insurance claims.

I verify that all information provided regarding my insurance is accurate. I will notify **Apex Mobile Wellness** office staff if any changes are made to my insurance. I authorize release of records upon request. A photocopy of these assignments shall be valid as the original.

X_____

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Signature of Patient (or patient's parent or guardian) Print Name Date