Acebo Health Center

PATIENT REGISTRATION FORM

Last Name _____ First _____ Middle_____

Date of Birth_____ /_____ /_____ Social Security Number _____ - _____ - _____ Email _____

Home Ph.(_____) _____ Cell Ph.(_____) _____ Work Ph.(_____) _____

Address_____ Apt/Unit:_____ City:_____ State:_____ Zip:_____

Employer _____ Occupation _____

How did you hear about us: _____ Who should we thank for referring you? _____

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Sex ❑Male ❑Female Marital Status ❑Single ❑Married ❑Widowed ❑Divorced Language ❑English ❑Spanish Other_____

Race ❑White ❑Black ❑Hispanic ❑Asian Other _____ Ethnicity ❑Hispanic/Latino ❑Non-Hispanic Other_____

****

Primary Insurance Name _____ Policy# _____ Group# _____

Name of Policy Holder or Insured_____ DOB____ /____ /____ Relation to Patient _____

Secondary Insurance _____ Policy#_____ Group# _____

Name of Policy Holder (Insured): _____ DOB:_____ /_____ /_____ Relation to Pt:_____

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Preferred Pharmacy _____Phone (_____) _____ Address _____

I give consent to send my appointment reminders/communication via (Select all that apply) ❑cell phone ❑home phone, ❑text message, ❑ email or ❑ I do not give consent.

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Emergency Contact_____ Relationship _____ Phone# (____)_____

Would you like to designate a personal representative to discuss your personal health information with? (You may revoke this designation at any time). ❑ NO ❑ YES

Representative _____ Relationship_____ Phone#: (_____)_____

We will accept your insurance after we verify that you have satisfied your annual deductible and if the reason for your visit is covered under your policy. My signature authorizes the release of my (and my dependents) medical information to the insurer or agency shown necessary to pay the claim by paper or electronically. I authorize my insurance company and/or government benefits to pay directly this office for services furnished to my dependents or me. I agree to be responsible for any copayments, coinsurance, deductibles, and/or non-covered services required by my plan benefit summary. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt. I certify that the information given by me is complete and accurate. I have read and understand all of the above and have agreed to it. I understand that a 24-hour notice for cancelled or reschedule appointments is necessary in order to avoid a cancellation fee of $25.00. This allows time to schedule another patient that would also benefit from medical services and treatments. This appointment policy allows developing a mutual consideration and respect for my time and this office.

PATIENT SIGNATURE (or legal guardian if minor) _____ DATE _____

Please present Insurance Card(s) and Photo ID to the receptionist. Thank you and welcome to our medical office.

Acebo Health Center

PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth _____ /_____ /_____ Age_____

Reason(s) for today's visit _____ Duration _____

Where is the problem located? _____ When did the symptoms start? _____

What medications have you used? _____

Do you have any allergies to Medications? ❑N ❑Y List medication(s)_____

Women Only:

Are you pregnant, planning a pregnancy or nursing a child? ❑N ❑Y _____

Do you take oral contraceptives? ❑N ❑Y List _____

PAST MEDICAL HISTORY

Please, check all that are positive:

- ❑ I am Healthy
- ❑ Thyroid Disease (□ Hyper / □ Hypo)
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ History of Heart Attack
- ❑ Pacemaker
- ❑ Asthma
- ❑ Respiratory Allergies
- ❑ History of Hepatitis
- ❑ Skin Cancer: □ Melanoma, □ Non Melanoma
- ❑ Bleeding disorder
- ❑ HIV/AIDs
- ❑ Hormone Imbalances
- ❑ Other: _____

Had you had any surgeries? ❑N ❑Y List: _____

Do you take any medications? ❑N ❑Y (List below)

_____ _____ _____

_____ _____ _____

_____ _____ _____

FAMILY MEDICAL HISTORY

	Specify Health Conditions	If not alive, specify the cause and age of passing
Father		
Mother		
Siblings		

SOCIAL HISTORY

Occupation? _____ Do you smoke? ❑N ❑Y How much per day? _____ For how many years? _____

If you smoked in the past, how much did you smoke per day and for how many years? _____

Do you drink? ❑N ❑Y How many drinks per day? _____ Do you use drugs? ❑N ❑Y _____

PATIENT SIGNATURE (or legal guardian if minor) _____ DATE _____

Acebo Health Center

PATIENT NOTICE
CONSENT FOR TREATMENT
AUTHORIZATION FOR TREATMENT
ASSIGNMENT OF BENEFITS

I hereby authorize Acebo Health Center providers to examine and treat me, including any procedure(s) as deemed necessary to provide health care and aid in the diagnosis of my health care conditions. I understand that any procedure involves certain risks including but limited to bleeding, infection, and scarring.

I authorize Acebo Health Center to take photographs of me for my medical record and educational purpose. I understand that the photographs may include appropriate portions of the body to demonstrate procedure(s) and that every effort will be made to protect my identity. I understand that cosmetic procedures require before and after pictures.

I understand that I may be billed by an outside laboratory. Blood and body tissue are sent to an outside laboratory for proper diagnosis and documentation. I understand that the laboratory directly bills your insurance for those services, and these charges are independent of any services provided at our office.

I authorize that the payment of insurance benefits be made on my behalf to Acebo Health Center for any services furnished to me. I further understand that prior to disbursing payment for services, my insurance company may require documentation from my medical records in order to process claim and approve payment.

I understand that my insurance may not cover certain procedures and/or medications. I further understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles and co-insurance payments. I agree to assume full responsibility for the balance not covered.

_____ _____
PATIENT SIGNATURE (or legal guardian) DATE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided by ***ACEBO HEALTH CENTER*** the **"**Notice of Privacy Practices", and I am giving my consent for the use and disclosure of Protected Health Information as required and /or permitted by law.

Patient Name: *(please print)* _____

Patient Signature: *(or legal representative; proof may be requested)* _____

Date: *(mm/dd/yy)* _____

EMAIL/TEXT MESSAGE TO MOBILE PHONE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. ACEBO HEALTH CENTER., (AHC) offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. AHC will use reasonable means to protect the security and confidentiality of email/mobile text messaging information sent and received. However, AHC cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between AHC and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is: _____

My Consented Phone Number for Text Messaging: _____

_____ _____
PATIENT SIGNATURE (or legal guardian) DATE