Name:____ Date:_________________________
Address: ____ Phone:_______________________
Primary Insurance: ________________________ Secondary Insurance: _________________
Pharmacy Preference: ____

General
- ☐ Weight loss or gain
- ☐ Excessive tiredness
- ☐ Persistent fever or chills
- ☐ Loss of Strength
- ☐ Trouble sleeping

Head & Neck
- ☐ Headache
- ☐ Head injury: explain ________________
- ☐ Neck pain

Eyes
- ☐ Vision loss or changes
- ☐ Blurry or double vision
- ☐ Tearing or redness
- ☐ Flashing lights or specks
- ☐ Eye pain
- ☐ Glaucoma

Ears
- ☐ Decreased Hearing
- ☐ Ringing in Ears
- ☐ Earache

Nose
- ☐ Stuffiness & Pressure
- ☐ Drainage
- ☐ Itching
- ☐ Nosebleeds

Throat & Mouth
- ☐ Dry Mouth
- ☐ Mouth Ulcers
- ☐ Hoarseness
- ☐ Trouble Swallowing
- ☐ Sore Throat
- ☐ Dentures

Cardiovascular
- ☐ Chest pain, tightness or discomfort
- ☐ Irregular heartbeat
- ☐ History of heart murmur
- ☐ Poor circulation
- ☐ Difficulty breathing lying down
- ☐ Swelling

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Sputum production
- ☐ Coughing up blood
- ☐ Painful breathing
- ☐ Sudden awakening from sleep with snoring or shortness of breath
- ☐ Positive TB skin test

Gastrointestinal
- ☐ Nausea or vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Rectal bleeding or hemorrhoids
- ☐ Abdominal pains
- ☐ Yellow eyes or skin
- ☐ Bloating

Urinary
- ☐ Frequency or urgency
- ☐ Burning or pain
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Sexual dysfunction

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Leg cramping or restlessness
- ☐ Stiffness
- ☐ Injuries (explain & date)
  ____
  ____
  ____

Skin
- ☐ Changing spots on skin
- ☐ Itching
- ☐ Rash

Neurologic
- ☐ Dizziness or balance problems
- ☐ Fainting
- ☐ Seizures
- ☐ Tingling or numbness
- ☐ Paralysis
- ☐ Tremor

Psychiatric
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Troubling thoughts
- ☐ Memory loss or confusion

Endocrine
- ☐ Heat or cold intolerance
- ☐ Abnormal hair growth
- ☐ Abnormal hair loss
- ☐ Frequent urination
- ☐ Extreme thirst

Hematologic
- ☐ History of anemia
- ☐ Ease of bruising or bleeding

Allergy
- ☐ Drug allergy and reaction (list):
  ____
  ____
- ☐ History of steroid use

For Women
- ☐ Breast lumps and/or pain
- ☐ Doing breast self-exams
- ☐ Breast-feeding
- ☐ Pelvic pain
- ☐ Vaginal discharge or itching
- ☐ Menstrual period irregularities
  Date LMP:
- ☐ Number of:
  Pregnancies ______
  Live births ______
  Miscarriages ______
  Abortions ______

Current Medications

____
____

Use back of sheet if needed

H:_______ W:______ BP:______ T:_______ P:_______ R:_______ O2:______ BS:______ HC:______ Chest:______ R-______ L-______

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last) | (First) | (Middle) | (Jr, Sr, etc.)

Gender ☐ M ☐ F	**Social Security Number:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated	**Date of Birth:** / /
What is your race? ☐ Asian ☐ Native Hawaiian ☐ Other pacific Islander ☐ Black/African American ☐ American Indian/Alaskan Native ☐ White ☐ More than one race ☐ Other	**What is your ethnicity?** ☐ Hispanic / Latino ☐ Not Hispanic / Latino	**What is your primary language?** ☐ English ☐ Spanish ☐ Other: ____________	**Who is your provider at CHS?**

Full Address (Street or P.O. Box) | (Apt #) | (City) | (State) | (Zip)

Home Phone #: ( )	**Cell Phone #:** ( )	**Work Phone #:** ( ) Ext.	**Email Address:**

Please be prepared to present your insurance card, photo identification and proof of income documentation, if necessary

RESPONSIBLE PARTY (complete if different from above)

Relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Grandchild ☐ Foster Child ☐ Guardian ☐ Mother ☐ Father ☐ Other:____________

Name (Last) | (First) | (Middle) | (Jr, Sr, etc.)

Gender ☐ M ☐ F	**Social Security Number:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated	**Date of Birth:** / /
Home Phone #: ( )	**Cell Phone #:** ( )	**Work Phone #:** ( ) Ext.	**Email Address:**

Full Address (Street or P.O. Box) | (Apt #) | (City) | (State) | (Zip)

INSURANCE INFORMATION (If uninsured, please be prepared to provide proof of income to qualify for discount program)

Primary Insurance (carrier name)		**Insurance Address**		**Phone Number** ( )
Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relationship to the patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other:_______	**Co-Pay ($)**
Secondary Insurance (carrier name)		**Insurance Address**		**Phone Number** ( )
Policy Holder ID (Subscriber ID)	**Group #**	**Subscriber Name**	**Relationship to the patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other:_______	**Co-Pay ($)**

If you have more than two insurances, please provide the additional information at the time of registration.

ADDITIONAL REQUIRED INFORMATION

Emergency Contact (Name) | (Address) | (Phone) | **Relation to Patient**

HOW CAN WE BE PRAYING FOR YOU TODAY?

AUTHORIZATION AND ASSIGNMENT

I do hereby voluntarily consent to medical care at Crossover Health Services (CHS). I hereby authorize all physicians and their assistants including Physician Assistants and Nurse Practitioners employed by CHS to use such diagnostic and treatment procedures they deem necessary for proper medical management and treatment. I understand that Physician Assistants and Nurse Practitioners are not licensed physicians and may help provide medical care only under the supervision and direction of a licensed physician. I also assign the claim payments to be made payable to CHS. I agree to the release of information to Medicare, SoonerCare and third party payors. I understand that some of the services that may be ordered may not be covered under Medicare, SoonerCare and other insurance and that I am responsible for any amount that is not paid. THIS AUTHORIZATION AND ASSIGNMENT IS A PERMANENT ONE-TIME SIGNATURE WHICH WILL REMAIN ON FILE AND WILL BE USED FOR FUTURE CLAIMS. I MAY REVOKE IT AT ANY TIME BY WRITTEN NOTICE.

Signature of Patient/Responsible Party:________________________________ **Date:**______________

MEDICAL PROFILE

VISIT DATE

/ /

PATIENT NAME IN FULL:

☐ M
☐ F

AGE

DATE OF BIRTH

/ /

PERSONAL AND FAMILY HISTORY

DESCIPTION	PERSONAL	FAMILY	RELATION	DESCIPTION	PERSONAL	FAMILY	RELATION
Hearing problems (code)	☐	☐		High Cholesterol (code)	☐	☐	
Heart disease (code)	☐	☐		Epilepsy (code)	☐	☐	
High blood pressure (code)	☐	☐		Seizures (code)	☐	☐	
Stroke (code)	☐	☐		Migraine headaches (code)	☐	☐	
Asthma (code)	☐	☐		Headaches (code)	☐	☐	
Emphysema (code)	☐	☐		Arthritis (code)	☐	☐	
Bronchitis (code)	☐	☐		Gout (code)	☐	☐	
COPD	☐	☐		Depression (code)	☐	☐	
Stomach Ulcers (code)	☐	☐		Anxiety (code)	☐	☐	
Constipation (code)	☐	☐		Diabetes (code)	☐	☐	
Diarrhea	☐	☐		Hepatitis (code)	☐	☐	
Digestive problems (code)	☐	☐		Liver problems (code)	☐	☐	
Drug problems (code)	☐	☐		Thyroid disease (code)	☐	☐	
Alcohol problems (code)	☐	☐		Sleep apnea (code)	☐	☐	
Cancer: Breast (code)	☐	☐		Anemia (code)	☐	☐	
Colon (code)	☐	☐		HIV / AIDS / STDs (code)	☐	☐	
Prostate (code)	☐	☐		Tuberculosis (code)	☐	☐	
Other: (code)	☐	☐		Osteoporosis (code)	☐	☐	
Kidney stones (code)	☐	☐		Blood Disease (code)	☐	☐	
Kidney Infections (code)	☐	☐					
Kidney failure (code)	☐	☐					

SOCIAL HISTORY

Smoking: ☐ Yes ☐ No	_______ : # per day or _______ : packs per day	# of years:_______	
Alcohol:	☐ Yes ☐ No	Frequency:	
Caffeine Drinks:	☐ Yes ☐ No	Frequency:	
_____ : # of pregnancies	_____ : # of live births	_____ : # of Miscarriages	_____ : # of abortions

HOPITALIZATION / SURGERIES / DIAGNOSTIC TESTS

HOPITALIZATION / SURGERIES / DIAGNOSTIC TESTS	DATE	HOPITALIZATION / SURGERIES / DIAGNOSTIC TESTS	DATE

MEDICATION ALERGIES

Have you ever had a bad reaction to a drug that you have taken? ☐ No ☐ Yes

Name of the drug	Type of Reaction

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ date:_____________ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.