NORTH OAKLAND INTERNISTS

PATIENT REGISTRATION

Name_____ SS# xxx-xx-_____ DOB_____

Street Address_____ City, State, Zip Code_____

Home #_____ Cell#_____ Work#_____ Gender: M or F

Employer_____ Address_____

Spouses Name_____ EMAIL_____

Emergency Contact_____ Phone_____ Relationship_____

IMPORTANT

Information below is required to meet Federal Electronic Health Record Requirements

Primary Contact Number: (Circle One) Home Cell Work

Race Choices: ☐ White ☐ American Indian ☐ Black ☐ Asian ☐ Unknown_____

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Unknown _____

Language: Primary_____ Secondary_____

RESPONSIBLE PARTY INFORMATION

Persons Name That Appears On Insurance Card

Relationship to Patient: SELF SPOUSE FATHER MOTHER GUARDIAN OTHER

Name_____ SS#_____ DOB_____

Address_____ Home #_____ Cell_____

Employer_____ Work #_____

INSURANCE INFORMATION

Primary Insurance_____ Secondary Insurance_____

****Please Bring Your Insurance Cards To Your Appointments****

IF THIS IS A WORKERS COMP OR A MOTOR VEHICLE ACCIDENT CLAIM, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Claim # _____ Contact/Adjustors Name_____

Date Of Incident/Accident _____ Contact/Adjustors Phone #_____

Claim Mailing Address_____

LOCAL/RETAIL PHARMACY INFORMATION

Name_____Phone_____

Address_____City_____State_____ZipCode_____

MAIL ORDER PHARMACY INFORMATION

Name_____Phone_____

Address_____City_____State_____ZipCode_____

If you would like to allow medical information to be shared with family/friend, please list below:

Name	Relationship	Phone
Name	Relationship	Phone

By signing below, you acknowledge you are at least 18 years of age, have read, understand and agree this release of information is authorized by you. This agreement will be valid for one year. If you wish to revoke this authorization, it must be done in writing.

Signature_____ Date_____

Relationship to patient (if not patient)_____

CRITTENTON

GENERAL CONSENT TO OUTPATIENT TREATMENT

CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his/her assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues. If the specimen contains fetal tissue and you do not select a private funeral home, then CHMC may send the tissue to the funeral home providing service to CHMC where it will be cremated with other tissue from CHMC.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including but not limited to: ***commercial pharmacies (i.e., Walgreens, CVS) for verification of my medications; and records related to behavioral health and substance abuse treatment***.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis B virus) tests may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

I expressly consent for the hospital, its providers and agents to place calls to my cellular and/or residential telephone using artificial or pre-recorded voice or auto-dialer technologies for any follow-up purposes, including billing and collections.

I am also aware that the hospital has available to me a Financial Assistance Policy that could affect the amounts payable._____initials

MEDICATION & MEDICAL DEVICE ASSISTANCE PROGRAM

In some cases, the hospital may be able to obtain reimbursement for some of your medications or medical devices from companies that manufacture them. In the event this occurs, the charge for the medication or medical device is removed from your bill for that hospital stay. Most of these programs require your signature on the application forms. In order to avoid you having to sign this application for each medication or device, we are requesting that you allow a Pharmacy Health Solutions ("PHS") representative to sign these forms on your behalf.

I appoint PHS to carry out in my name, the application forms required for PHS to obtain reimbursement for my medications or medical devices from manufacturers. This signature will be in full force from the date signed.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES

I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

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I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

Signature of Patient _____ **Date**_____ **Time** _____

Name of Patient (print) _____

Signature of Spouse_____ **Date**_____ **Time** _____

Signature of Witness_____ **Date**_____ **Time** _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____ **Date**_____ **Time**_____

Relationship_____

Address_____Phone Number _____

Signature of Witness_____ **Date**_____ **Time**_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

The Crittenton Hospital Medical Center Notice of Privacy Practices and Patient Rights and Responsibilities provides information about how protected health information about me (the patient) – may be used and disclosed. I understand that the terms of the Notice may change and that I may obtain a current copy by accessing the Crittenton Hospital Medical Center website at www.crittenton.com or by contacting the Privacy Officer listed in the Notice.

The Patient Rights and Responsibilities handout provide information about patient rights, benefits, or privileges guaranteed by law. I understand that the law may change and that I may obtain a current copy by accessing the Crittenton Hospital Medical Center website at www.crittenton.com or by contacting the Patient Relations Department.

I acknowledge that I have been provided the Crittenton Hospital Medical Center Notice of Privacy Practices and the Patient Rights and Responsibilities handout.

Name of Patient (print) _____

Signature of Patient _____ **Date**_____ **Time**_____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____ **Date**_____ **Time**_____

Relationship_____

NORTH OAKLAND INTERISTS, P.C.

OUR MEMO OF UNDERSTANDING

Thank you for choosing our medical practice as your home base for your medical care. We appreciate the trust and confidence you have placed in us. Our goal is to provide you with complete, continuing and personal medical care. For this goal to be possible, it is important that we each commit to fulfilling certain responsibilities.

Physician Responsibilities

- Listen to you as to your health care matters, and encourage a culture of open, full and frank communication.
- Provide counsel and information regarding the different treatment plans for chronic conditions or prevention programs.
- When possible, provide convenient options including electronic access for non-urgent communications for scheduling office visits and follow up visits, and for obtaining test results and referrals.
- Provide flexible and expanded office hours, schedule appointments within a reasonable time, and see patient as closely as reasonably possible to scheduled appointment time.
- Provide telephone availability to physician for urgent communications 24 hours per day, 7 days per week.
- As technology develops, provide convenient options for non-urgent communications between patient and physician including post-hospital support, follow up visits and consultations.
- Use a team approach to health care by providing access to other clinicians and health care institutions when and where appropriate.
- Coordinate and integrate care provided by my practice team and other clinicians and health care institutions effectively to avoid duplication, delay and error.
- Share necessary health information with other members of patient's health care team, when appropriate, to support and deliver comprehensive, quality care.
- Share appropriate health information with health information exchanges.
- Communicate test and treatment results promptly and accurately.
- Provide information, recommendations and advice regarding preventive care, maintaining wellness, self-management direction and counseling.
- Send reminders of the need for follow up care and preventive care.
- Maintain clinical information in a format that allows for ready search, retrieval and information transfer while protecting privacy and confidentiality, including participating in the development and maintenance of standardized electronic health records and patient registries.
- Coach the medical home base staff in the responsibilities described above.

Patient Responsibilities

- Communicate openly, fully, frankly and proactively with physician and physician's staff.
- Be an active participant in the development with physician of action plans and treatment plans for patient's acute or chronic condition, and follow agreed-upon treatment plans.
- Provide physician with feedback regarding patient's treatment plan.
- Appear on time for appointments, procedures and other medical tests at physician's office, and timely submit materials, samples and information as requested by physician.
- Schedule and attend follow up appointments at intervals suggested by physician.
- Involve yourself in physician's and other health care professionals' recommendations with respect to maintenance or improvement of patient's health and wellness.
- Participate in action planning and goal setting with respect to maintenance or improvement of patient's health and wellness.
- Participate in developing and maintaining a comprehensive health record by authorizing delivery and circulation of clinical information to and from clinicians and health care institutions.

Please take the time to carefully read this Memo of Understanding and sign your name in the appropriate place below.

_____ _____

Patient /Caregiver Signature **Physician Signature**

Today's Date: _____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes - Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
1.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N		☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Education ☐ Less than 8th grade
☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level
☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? ____

Alcohol Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? __

Tobacco Do you use tobacco?
☐ Yes ☐ No
If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes -____pks./day
☐ Chew - ____/day
☐ Cigars - ____/day
☐ # of years____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____
Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

☐ Chickenpox	Date:_____	☐ Meningococcus	Date:_____
☐ Flu Shot	Date:_____	☐ MMR *(Measles, Mumps, Rubella)*	Date:_____
☐ Gardasil/HPV	Date:_____	☐ Pneumonia	Date:_____
☐ Hepatitis A	Date:_____	☐ Tdap *(Tetanus and pertussis)*	Date:_____
☐ Hepatitis B	Date:_____	☐ Tetanus	Date:_____
		☐ Zostavax *(Shingles)*	Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
☐ Cesarean sections If yes, then number: _____

☐ Bleeding between periods
☐ Heavy periods
☐ Extreme menstrual pain
☐ Vaginal itching, burning, or discharge
☐ Wake in the night to go to the bathroom
☐ Hot flashes
☐ Breast lump or nipple discharge
☐ Painful intercourse
☐ Sexually active
Current sexual partner is ☐ Female ☐ Male
Do you use condoms ☐ Yes ☐ No

Other Birth control method used:_____
☐ Interested in being screened for STD's

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

_____ _____

Parent, Guardian, or Caregiver Signature Date