Patient Registration

Last Name_____ First Name_____ MI_____

Address_____ City/State/Zip _____

Home #_____ Work #_____ E-mail_____

Birth Date___/___/___ Sex ☐M ☐F ☐Married ☐Single ☐Other Soc. Sec. # ___-___-____

Ethnicity_____ Race _____ Language _____

Emergency Contact & Phone_____Physician_____

Guarantor (Responsible For Account)

Last Name_____ First Name_____ MI_____

Address_____ City/State/Zip _____

Home #_____ Work #_____ E-mail_____

Birth Date___/___/___ Sex ☐M ☐F ☐Married ☐Single ☐Other Soc. Sec. # ___-___-____

Insurance Information (COPY CARD(s) FRONT & BACK)

Primary Insurance Company_____ Policy #_____

Group #_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First_____ MI_____

Birth Date___/___/___ Sex ☐M ☐F Home #_____ Work #_____

Employer_____ Co Pay $ _____ Referral Needed? ☐Y ☐N

Secondary Insurance Company_____ Policy #_____

Group #_____ Relationship to Patient_____ Effective Date_____

Policy Holder's Last Name_____ First_____ MI_____

Birth Date___/___/___ Sex ☐M ☐F Home #_____ Work #_____

Employer_____ Co Pay $ _____ Referral Needed? ☐Y ☐N

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits (including Medicare) to be paid directly to Yakima Medical Clinic for services rendered. I also authorize Yakima Medical Clinic to release any information requested by the insurance company with regard to payment of benefits.

PATIENT'S SIGNATURE (OR LEGAL GUARDIAN) DATE

HEALTH HISTORY
(Confidential)

Name: _____
Occupation: _____

Phone: _____
Referring Physician: _____

The MAIN REASON for my appointment today is:

_____
_____
_____

MEDICAL HISTORY:
I have these medical problems

1. Anemia
2. Diabetes
3. Thyroid disorder
4. Seizures (epilepsy)
5. High blood pressure
6. Heart disease
7. Rheumatic fever
8. Asthma or Emphysema
9. Kidney problems
10. Intestinal problems
11. Liver disease or hepatitis
12. Prior blood transfusion
13. History of blood clots
14. Bleeding disorder
15. Low platelets
16. Lupus or arthritis
17. History of anesthetic reaction of anesthetic
18. History of cancer
19. Other: _____

Describe_____

_____

_____

20. No known medical problems.

I smoke: No/Yes _____packs/day

I drink: Never, Rarely, Weekends, Daily

MEDICATIONS:

_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____

CARDIOVASCULAR SURVEILLANCE

My Cholesterol was last checked _____(approx date
Cholesterol level _____ if known)

I have risk factors for heart or vascular blood vessel disease:
____A family history of heart attack or stroke
____ I currently smoke
____ I have high blood pressure
____ I have been told my cholesterol is high
____ I have diabetes or am significantly overweight

SURGERIES AND HOSPITALIZATIONS:

APPROXIMATE DATE (YEAR) / REASON FOR HOSPITALIZATION OR THE TYPE OF SUGERY

1. _____/_____
2. _____/_____
3. _____/_____
4. _____/_____
5. _____/_____
6. _____/_____
7. _____/_____
8. No Surgeries / or hospital

FAMILY HISTORY:

Please circle and of the medical problems found in you family (include immediate family & grandparents). Also list who is affected.

1. Breast cancer _____
2. Ovarian Cancer _____
3. Colon Cancer _____
4. Other types of cancer _____
5. Diabetes _____
6. High blood pressure _____
7. Heart disease _____
8. Stroke _____
9. Other medical problems _____

_____

10. No medical problems in family

Signature: _____

Date_____

Yakima Medical Clinic
Patient Privacy Questionnaire

PATIENT NAME: _____ DATE: _____

Please list the family members or the other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, account information and health care operations):

NAME: _____ NAME: _____

NAME: _____ NAME: _____

NAME: _____ NAME: _____

Please list the family members or significant others if any, whom we may inform about your medical condition **ONLY IN A EMEREGENCY:**

NAME: _____ NAME: _____

NAME: _____ NAME: _____

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

_____

I acknowledge that my PHI (Private Health Information) may be dispersed via E-Mail, Internet, Electronic Billing, Facsimile machine ad U.S. Postal Service and give my consent for any one of these means to be utilized.

YES_____ NO _____

Please print the telephone number where you want to receive call about your appointments, lab and x-ray results, account information, or other health care information other than your home number:

_____

I am fully aware that a cell phone is not a secure and private line

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____

RELATIONSHIP TO PATIENT

NOTICE OF PRIVAVCY PRACTICES --- ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Yakima Medical Clinic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of Notice of Privacy Practices.

_____	_____	
Patient or legal authorized individual signature	Date	Time

This form will be retained in your medical record

Last Update: ____/____/____