Salmon Falls
family healthcare

www.SalmonFallsMD.com

# ***Adult*** Patient Registration

**Name** (First, MI, Last):_____ **Gender**: ☐ Male ☐ Female

**Date of Birth:** _____/_____ /_____ **Marital Status:** ☐ Single ☐ Married **Social Security #**: _____ - _____ - _____

**Mailing Address**:_____ **City/State:** _____**Zip Code:** _____

**Street Address**:_____ **City/State:** _____**Zip Code:** _____

**Phone** (Home):_____ **Phone** (Cell):_____ **Phone** (Work):_____

**Email**: _____

***Emergency Contact***: _____

Relationship: _____ Phone:_____

- Can the above listed contact (with photo identification) pick up prescriptions if you are unavailable?
  ☐ Yes ☐ No

If you would like to give us permission to release/discuss personal information in your medical record with someone other than yourself, please fill out the **Authorization Form: PHI Release Authorization**.

We may need to communicate upcoming appointment information, test results and/or other information regarding your medical care. What is the best phone number for contact where we may also leave messages?
☐ Home ☐ Cell ☐ Work

***Race***
☐ White
☐ Black or African American
☐ Asian
☐ Other: _____
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander

***Preferred Language***
☐ English
☐ Other:_____

***Ethnicity***
☐ Non-Hispanic or Latino
☐ Hispanic or Latino
☐ Other

**The above information is thorough and accurate to the best of my knowledge.**
**For any changes to the above information, I will notify the office.**

**PATIENT/Authorized Person SIGNATURE: _____ Date: _____**

**Authorized Person NAME (print): _____ Relationship: _____**

CPS Update/Staff Initial ☐

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# Consents and Terms

**Patient Name** (First, MI, Last):_____ **Date of Birth:** _____/_____ /_____

***Insurance Information**** *(fill out completely)*

*Primary Insurance*: _____

Insurer ID#:_____

Group #:_____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth:_____

Relationship to patient:

☐ Self ☐ Spouse ☐ Other

*Secondary Insurance*: _____

Insurer ID#:_____

Group #:_____

Claims Address: _____

Subscriber: _____

Subscriber's Date of Birth:_____

Relationship to patient:

☐ Self ☐ Spouse ☐ Other

***Workers Compensation***

Company _____ Address _____

Claim # _____ Date of Injury _____ Body Part Covered _____

Case Manager _____ Phone Number _____ Ext_____

Employer at time of injury_____ Contact Name/Phone_____

Attorney Name_____ Phone_____

**Please let us know if you have any questions.**

**Payment Policy:** Payment is due at time of service: Co-pays are due; Full payment is due for self-pay patients. Cash or credit cards (Visa, MasterCard and Discover) are accepted. On a limited basis checks may be accepted. There is a service charge on any returned check; full payment required within 10 days of notice.

**Insurance:** The office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. You have the **ultimate responsibility of verifying the coverage with your insurance.** You acknowledge that we may be an out of network provider with your insurance. If your insurer sends payment directly to you, you agree to endorse the insurance check and forward funds to the appropriate entity above within 30 days of receipt. Patients who do not supply accurate and/or updated insurance information are Self-Pay.

**Insurance Referrals:** If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you are responsible for charges.

**Missed Appointments:** If you are unable to keep an appointment you must notify the office at least 24 hours prior to your scheduled appointment. If you "no-show" or cancel without sufficient notice, you may be subject to a 'no show' cash fee, payable by you, not your insurance company.

**The above information is thorough and accurate to the best of my knowledge. I will notify the office of any changes within 30 days. If I do not notify the office of insurance changes, I am fully financially responsible.**

I understand that rude or disrespectful treatment of staff is not tolerated and may result in my discharge. (e.g. using profanity, raising my voice, making vulgar or inappropriate comments).

I understand that my health is my own, not my families' or spouse's. Therefore, I need to be the person to communicate with the provider and his/her staff if at all possible

I consent to evaluation and treatment by any Salmon Falls Family Healthcare provider. I authorize my Provider to communicate with other providers regarding my treatment and care.

I acknowledge that I have a copy and/or access to the Notice of Privacy Practices.

I authorize release of records and information for treatment, payment and healthcare operations.

I authorize my insurance carrier to pay benefits for services rendered, directly to PMC Medical Group, LLC or any of its affiliates. I am financially responsible for claims denied or not covered by my insurance carrier.

**I have read and agree to the terms of the above information.** CPS Update/Staff Initial ☐

**PATIENT/Authorized Person SIGNATURE: _____ Date: _____**

**Authorized Person NAME (print): _____ Relationship: _____**

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# Adult Health History Form

**Name:**_____ **Date Of Birth:**_____/_____/_____

Who was your previous primary care provider? _____

Reason for today's visit:_____

## *CURRENT MEDICATIONS*

| **Name of Medication** | **Strength** (ex. 500 mg) | **Dosing Instructions** (ex. Twice a day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## *ALLERGY HISTORY*

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

| **Allergen** (ex. Food, Dust, Animals, Pollen, Medication) | **Reaction** (ex. Rash, nausea, respiratory, shock, etc.) |
|---|---|
| | |
| | |
| | |
| | |

## *MEDICAL HISTORY* (Please check any of the following that you have or have had in the past)

☐ Acid Reflux/GERD
☐ ADHD
☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Bowel Problems
☐ Cancer
☐ Chronic Cough
☐ Chronic Pain
☐ COPD/Emphysema
☐ Dementia
☐ Depression
☐ Diabetes
☐ Eating Disorder
☐ Glaucoma/Cataracts
☐ Headaches
☐ Hearing Loss
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney Disease
☐ Immune Disorders
☐ Liver Disease
☐ Osteoporosis
☐ Seizure Disorder
☐ Sexually Transmitted Disease
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Other: _____

## *SURGICAL HISTORY* (Please list all past surgeries/operations):

| **Type of Operation** | **Date** | **Type of Operation** | **Date** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***MEDICAL AND MENTAL HEALTH HISTORY*** (Include all injuries or hospitalizations)**:**

| Name of Facility | Reason | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***FAMILY HISTORY*** *(Please tell us about the health of your immediate family)*

| | Father | Mother | Siblings | Children | Other |
|---|---|---|---|---|---|
| **Age at Death** | | | | | |
| **Cause of Death** | | | | | |
| **Heart Disease/ Stroke** | | | | | |
| **High Blood Pressure** | | | | | |
| **Diabetes** | | | | | |
| **Cancer (type)** | | | | | |
| **Epilepsy** | | | | | |
| **Asthma** | | | | | |
| **Blood Disease** | | | | | |
| **Other:** | | | | | |

***SOCIAL HISTORY*** *(Please circle all applicable responses)*

| | | |
|---|---|---|
| Marital Status | Single Significant Other Married Divorced Widowed | |
| Living Situation | Alone Spouse/Significant other Children/Family Other | |
| Females- Are you pregnant? | Yes / No Hysterectomy Menopause Tubal ligation | |
| Do you have children? | Yes / No | If yes, how many? |
| Do you have animals? | Yes/ No | If yes, how many? |
| Education (highest level) | 9 10 11 12 Some college Associates Bachelors GED Masters PhD | |
| Are you working? | Yes / No | If yes, occupation? |
| Are you disabled? | Yes / No | If yes, reason? |

| | | | **If applicable, amount?** |
|---|---|---|---|
| Tobacco Use?<br>*If no, have you ever?* | Yes / No<br>Yes / No | Cigarettes / Cigars / Chew<br>Cigarettes / Cigars / Chew | Per day:<br>Per day: |
| Exposed to second hand smoke? | Yes / No | | |
| Do you drink alcohol? | Yes / No | Beer / Wine / Liquor | Per day: |
| Do you drink caffeine? | Yes / No | Coffee / Tea / Soda / Energy Drink | Per day: |
| Any present illicit drug use? | Yes / No | Marijuana / Cocaine / Heroin / Illicit Rx. / Other | |
| Any past illicit drug use? | Yes / No | Marijuana / Cocaine / Heroin / Illicit Rx. / Other | |
| Do you exercise? | Yes / No | Type? | Per week: |
| Do you wear your seatbelt? | Yes / No | If yes, percent of time: | |
| Do you have Advanced Directives in place? | Yes / No | Living Will Durable Power of Attorney<br>Health Care Proxy Advanced Directives | |

## *PREVENTATIVE CARE HISTORY*

Please provide the dates and results of the following immunizations, examinations, and test to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

| | | | | |
|---|---|---|---|---|
| Last Tetanus Booster | ☐ Within past 10 years | ☐ More than 10 years ago | | ☐ N/A |
| Last Eye Examination | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Hearing Exam | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Colonoscopy or stool test | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Bone Density Scan | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Pneumonia Vaccine | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Flu shot this season? | ☐ Yes ☐ No | | | |
| *Women:* | | | | |
| Last Pap Smear | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Mammogram | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| *Men:* | | | | |
| Last Prostate Specific Antigen | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |
| Last Prostate Exam | Date:_____ | ☐ Normal | ☐ Abnormal | ☐ Unknown |

*The above information is thorough and accurate to the best of my knowledge.*

_____ _____

**Patient Signature (or Guardian)** **Date**