Patient Registration

First Name______________ Last Name______________ Middle Name, suffix________________

Preferred Name________________________ Former Last Name__________________

Sex______________ DOB__________________ SSN________-__________-_________

Address________________________________ City______________ State____ Zip_______

Home Phone (____) ____-_______ Mobile (____) ____-_______ ☐ No Phone Consent to text Yes ☐ No ☐

Work Phone (____) _____-_______ Patient Email ______________________________ ☐ No Email

Contact Preference___________________

Usual Provider_____________ Registration Dept______________ Primary Dept____________

Language____________________ Race______________ Ethnicity__________________

Marital Status_______________ Deceased Date__________ Homebound?______________

ID Number Override__________________ How did you hear about us?____________________

Patient Care Summary ☐ Portal ☐ Paper Patient Declined ☐

Guardian:

Last Name_________________ First Name ______________ Middle Name_______________

Emergency Contact:

Name________________________ Relationship__________ Phone (____) ______-___________

Next of Kin:

Name________________________ Relationship__________ Phone (____) ______-___________

Employment:

Employer Name_____________________________ Employer Phone (____) ______-__________

Usual Occupation (current or most recent)__________________ Usual Industry_______________

Guarantor:

Patient's relationship to guarantor______________

First Name________________ Middle Name_____________ Last Name_________________

DOB______________ SSN______-_______-________

Pharmacy:

Name_________________________ Phone (____) ____-______

Mailing Address:

Address________________________________ City______________ State____ Zip________

Privacy:

Notices on file

- ☐ Privacy Notice
- ☐ Release of Billing Information
- ☐ Assignment of Benefits

Consent to call ☐ Yes ☐ No

Medication History Authority ☐ Yes ☐ No

Patient Notes

____

____

____

Billing:

Hold Statements

- ☐ Apply hold statements to all copies of this patient's record
- ☐ Statements delivered online only

Statement Note

____

____

Statement Note Effective Date __________ to __________

Primary Insurance Information:

Insurance Plan Name______________________

Policy Holders First Name_____________ Middle Name__________ Last Name______________

Address________________________________ City______________ State____ Zip________

DOB_____________ Sex________

Secondary Insurance Information:

Insurance Plan Name______________________

Policy Holders First Name_____________ Middle Name__________ Last Name______________

Address________________________________ City______________ State____ Zip________

DOB_____________ Sex________

To the best of my knowledge the above information is complete and accurate.

Signed____Date_____________________

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for Pathways Medical

Signed____Date_____________________

I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed____Date_____________________

I authorize Pathways Medical to release medical information required to process my claim

Signed____Date_____________________

I have read and understand the Financial Policy for Pathways Medical

Signed____Date_____________________

I authorize Pathways Medical to obtain/have access to my medication history

Signed____Date_____________________

I authorize my provider's office to contact me by mobile phone

Signed____Date_____________________

Name:_______________________________

Date of Birth:___________ MRN#: ___________ CSN: ________

Consent and Agreement
Physician Services and Hospital Services

1. **Annual Consent for Services:** I consent to the services that may be performed by a Pathways Medical physician or non-physician provider ('provider') or facility. I understand I can withdraw this consent at any time. This consent and agreement applies to any provider services I may obtain from Pathways Medical providers at a clinic or physician's office and also to any hospital services I may obtain at a Pathways Medical hospital or from a hospital based clinic location.

2. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Pathways Medical Charge Description Master as of the date of treatment unless I am entitled to pay a different amount under my (or the patient's) health insurance plan or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Pathways Medical will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

3. **Assignment of Insurance Benefits:** I assign to Pathways Medical, my physician or other non- Pathways Medical healthcare professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the health insurance policy or the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

4. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Pathways Medical to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

5. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

6. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Pathways Medical clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Pathways Medical may pursue corrective action.

7. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Pathways Medical may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Consent and Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Pathways Medical website.

Name:____

Date of Birth:__________ MRN#: __________ CSN: __________

Consent and Agreement
Physician Services and Hospital Services
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8. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Pathways Medical may maintain a safe for small personal items of unusual value, Pathways Medical is not responsible for the loss or damage to these items.

9. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Pathways Medical of any changes as soon as possible.

10. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non- Pathways Medical providers such as radiologists, pathologists, and anesthesiologists, in addition to the Pathways Medical bill.

11. **Phone Calls:** I authorize Pathways Medical and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Pathways Medical from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages, even if I am charged for the call under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Pathways Medical and its collection agencies may monitor and/or record any communication.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: ______________________________ Date: __________ Time: __________

If signed by other than patient, indicate relationship: ______________________________

Witness: ______________________________ Date: __________ Time: __________

PROTECTED HEALTH INFORMATION

AUTHORIZED PERSON(S)

Please print below information

I, ____, hereby authorize release of my Protected Health Information for **verbal discussion only** of my care and treatment to the person(s) specified below (45CFR, 164.502[F] & 164.502[G]): Authorized family member or person to receive information for the above named patient's care:

______________________________ ____________________________ __________

Name of Central Contact (other than patient) Relationship to Patient Phone

Others authorized to receive my verbal information (please list names and relationship):

______________________________ ____________________________ __________

Name of Central Contact (other than patient) Relationship to Patient Phone

______________________________ ____________________________ __________

Name of Central Contact (other than patient) Relationship to Patient Phone

NOTE: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: if the release is needed in emergency situations.

May we include you in the clinic or hospital directory? o Yes o No
(Example : If you are in our clinic/hospital seeking treatment and a spouse or other family member calls to inquire if you are still there, can we say yes or no?)

Leave message on answering machine or voice mail? o Yes o No
(Example : We may leave message reminders , scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable, yes or no?)

Leave message for patient to return call? o Yes o No
(Example: We may leave a message regarding appointment reminders , scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable , yes or no?)

NOTE: By signing and dating this Protected Health Information Authorized Person(s) form, I revoke all previously signed Protected Health Information Authorized Person(s) forms.

Patient Signature ______________________________ Date ________________

Personal Representative __________________________ Relationship to Patient ____________
(PRINTED Name)

NOTE: Except to the extent that action has already been taken in reliance on this Protected Health Information Authorized Person(s), at any time I can revoke this Protected Health Information Authorized Person(s) by submitting a new Protected Health Information Authorized Person(s) form or by written notice to Pathways Medical where my medical records are kept

Patient Name:

Date of Birth:

INTERNAL MEDICINE 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:______
- ☐ Flu Shot Date:______
- ☐ Gardasil/HPV Date:______
- ☐ Hepatitis A Date:______
- ☐ Hepatitis B Date:______
- ☐ Meningococcus Date:______
- ☐ MMR *(Measles, Mumps, Rubella)* Date:______
- ☐ Pneumonia Date:______
- ☐ Tdap *(Tetanus and pertussis)* 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 ____________________________

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:

______

______

PATHWAYS MEDICAL

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I understand that records are protected under Federal and State Confidentiality Law and Regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I/we hereby authorize Pathways Medical, LLC ( ) to release to ( ) to receive from ______________________________ the following information/ records regarding: (Name of Client)______________________________
DOB ____-____-____.

Please initial:

____Social and Social Services information (history & current)
____Psychosocial/ Psychological/ Diagnostic Evaluation information (history & current)
____Health and Drug information, including immunizations (history & current)
____Educational Evaluation/ Planning, including related to special needs (history & current)
____Mental Health Treatment, Planning and Treatment Progress information (history & current)
____Drug/ Alcohol Abuse and related Treatment information (history & current)
____Drug/ Alcohol Test results and related information.
____Other:____.

Period of time covered: One (1) year for the date of my/our signature(s) unless otherwise specified below
Purpose: To Provide Information As Needed for Collaborative Care

Revoke upon this date:______________ Client/Guardian Initial ________ Date ____

The information authorized for release may include information which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known a Acquired Immune Deficiency Syndrome (AIDS).

I understand that my records are currently protecfed by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.
I/ we understand that I/we may revoke this consent at any time by initialing and dating above, except to the extent the aforementioned actions have been taken in reliance on it. If no revocation is made, this consent shall expire (1) year from the date of my/our signature(s) or upon the following date:__________.
I/we do not authorize further release to any other party. I/we understand that the individual entities involved in providing services-and their employees, officers, and directors- cannot be responsible for confidentiality of information disclosed after information has been released pursuant to this authorization, and I/we thereby release them from any liability arising from such disclosure.
This consent is being given freely and voluntarily, I understand that treatment services are not contingent upon or influenced by my decision to permit the release of information.
I understand that I am entitled to receive a copy of this authorization after it is signed.

Client	Date	Parent/Guardian	Date
Staff/Witness	Date	Clinician's Review	Date

Consumer Name: ______________, ______________
Last Name First Name

Form revision [illegible]