Comprehensive Internal Medicine

New Patient Registration Form

Today's date _____ /_____ /_____

Name_____ _____ _____

Last **First** **M.I.**

Date of birth ____ /____ / ____ **Social Security #** _____ **Male**___ **Female**___

Mailing Address_____

Street **City** **State** **Zip**

Home Phone: (_____) _____ **Employer Name**:_____

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

Email Address: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated ___

Emergency contact information

List someone **NOT** living in the household in case of emergency:

Name: _____ **Phone**: (_____)_____

Privacy information – HIPAA

Initial Only One Type!

_____Type A – I authorize Comprehensive Internal Medicine to leave a detailed message on my cell/work/home/text including scheduled appointments. (cross out any unwanted options)

I also authorize Comprehensive Internal Medicine to discuss any and all of my health and billing information to the following individuals:

Name: _____ **Relationship**: _____ **Phone**: (____) _____

Name: _____ **Relationship**: _____ **Phone:** (____) _____

_____ **Type B –** I authorize comprehensive Internal Medicine to leave information **ONLY** regarding my **Scheduled Appointments** on my cell/ home/work/ text or with anyone who answers the phone. (cross out any unwanted options)

_____ **Type C –** I **DO NOT** authorize Comprehensive Internal Medicine to discuss or release any of my information to anyone. I **DO NOT** want any messages left on any voicemail.

Comprehensive Internal Medicine

My signature below indicates that I have received and/or reviewed a copy of my physicians Notice of Use and Disclosure of Protected Medical Information (Notice of Privacy Practices). A copy is located in our office.

Patient Responsible Party Signature: _____ Date_____/_____/_____

I AUTHORIZE THE RELEASE OF ALL INFORMATION TO ANY PHYSICIAN OR INSTITUTE I MAY BE REFERRED TO BY COMPREHENSIVE INTERNAL MEDICINE.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute of payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deducible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL COST, WE REQUIRE ALL CO-PAYS AND DEDUCTABLES TO BE PAID AT TIME OF SERVICE.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and cost of collection.

I authorize the release of any information necessary to determine the liability for payment and to obtain reimbursement on any claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice names on the other side of this form.

This assignment will remain in effect until revoked by be in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charged whether paid by said insurance.

Patient or Responsible Party Signature: _____ Date_____/_____/_____

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List any allergies INCLUDING allergies to medications and there reaction

_____
_____
_____
_____

Immunizations – Circle if you have had any of the following immunizations and the year/date received.

FLU	PNEUMONIA	TETANUS/TDAP	PPD/TB TEST
HEPATITUS A / B	SHINGLES	HPV	OTHER-

Family History- CIRCLE one for Mother, Father, Grandparents, Brother, or Sister with any of these conditions.

ALCOHOLISM **F M G B S**	HIGH BLOOD PRESSURE **F M G B S**
BLOOD DISORDER- **F M G B S** What kind?	HIGH CHOLESTEROL **F M G B S**
CANCER- **F M G B S** What kind?	KIDNEY DISEASE **F M G B S**
DIABETES – **F M G B S** Insulin dependent? Type II?	OVARIAN/PELVIC DISEASE **F M G B S**
DRUG DEPENDENCY/ABUSE **F M G B S**	SEIZURES/EPILEPSY/STROKE **F M G B S**
EMOTIONAL/ANXIETY/DEPRESSION/SUICIDE **F M G B S**	THYROID **F M G B S**
HEART/LUNG DISEASE **F M G B S**	ULCER **F M G B S**
HEPATITIS/LIVER DISEASE **F M G B S**	LUPUS/MS/AUTOIMMUNE DISEASE **F M G B S**

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How often do you exercise in a week? _____ Duration: _____ LIGHT / MODERATE / HEAVY

(circle one)

Do you have a living will? Yes / No

Do you have a Power of Attorney? Yes / No

If yes who is your POA? _____

Please indicate any of the following:

Tobacco use: current **/** former **/** occasional **/** never

If current how many packs per day? _____ for how many years? _____

Cigars / Pipe / Smokeless Tobacco / E cigarettes (circle one)

When did you quit? _____

Caffeine use / how many per day? _____

Alcohol use – how often a week / month? _____

Illegal drug use? _____

Living situation- list who you live with- spouse, alone, with children, with parents, etc.

_____

List any overseas travel: _____

WOMEN ONLY- please indicate if you have ever had any of the following and list the date(s) if possible:

Number of pregnancies ____

Number of live births ____

Miscarriages / Abortions ____

SURGERY	DOCTOR/LOCATION	YEAR	COMPLICATIONS
APPENDECTOMY			
BREAST BIOPSY/MASTECTOMY			
C-SECTION			
CARDIAC SURGERY			
CATARACT SURGERY			
COLON/RECTAL SURGERY			
D&C			
GALLBLADDER REMOVAL			
HYSTERECTOMY			
KIDNEY/BLADDER			
TONSILECTOMY			
TUBAL LIGATION			
TUBES IN EARS			
VASECTOMY			
ORGAN TRANSPLANT			

Other surgeries (knee, hip, shoulder, thyroid, radiation, chemotherapy, etc.)

_____

_____

_____

Wellness prevention

Please indicate an approximate date when last done/how often done and who preformed if possible. Also indicate if normal/ abnormal if possible.

TEST PERFORMED	DATE WHEN LAST DONE	HOW OFTEN	DOCTOR WHO PREFORMED	NORMAL/ ABNORMAL
ANNUAL EYE EXAM				
BONE DENSITY				
COMPLETE SKIN EXAM				
PELVIC/PAP				
MAMMOGRAM				
COLONOSCOPY				
HIDA SCAN				
LAST COMPLETE PHYSICAL				

Specialists- if you see any specialists, please list them and indicate their specialty (cardiologist, Pulmonary/Lung, Oncologist, Hematologist, Urologist, Gastrologist, Dermatologist, OB/Gyn, etc.

_____
_____
_____
_____

REVIEW OF SYSTEMS:

Please circle only those symptoms you have experienced since last seen by a doctor.

Fatigue/weakness	Difficulty swallowing	Unexplained weight change	Constipation
Cough	Allergy/Sinus	Watery/Itchy eyes	Sleep trouble
Fever	Nasal drainage	Stomach pain	
Blood in stool	Shortness of breath	Headache	
Muscle aches	Nausea/Vomiting	Urinary complaints	
Skin lesions	Hair/Skin changes	Diarrhea	
Joint pain	Numbness/Tingling	Heart burn	
Passing out	Chest pain	Vision change	
Dizziness	Depression	Excess thirst	

CURRENT MEDICATIONS

Please list all current medications, including name, dose and reason you take it. Include vitamins and supplements.

Name of medication	Dose	Reason for taking it

What pharmacy do you use? _____ _____ _____

Name of pharmacy City zip

Comprehensive Internal Medicine

3727 Friendsville Rd. Wooster, OH 44691

Phone: 330-202-3434 Fax: 330-202-3435

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

_____ _____ / _____ / _____ (_____) _____ _____

Name of Patient **Date of Birth** **Phone Number**

_____ _____ _____ _____

Street Address **City** **State** **Zip**

AUTHORIZATION TO RELEASE INFORMATION

PLEASE **OBTAIN** INFORMATION **FROM** : PLEASE **SEND** INFORMATION **TO** :

_____ _____

(name of doctor) (**name of doctor**)

Street address) _____ Comprehensive Internal Medicine

City)_____ State)_____ Zip)_____ 3727 Friendsville Rd suite 2

Phone) _____ Wooster, OH 44691P

Fax)_____ Phone)330-202-3434 Fax) 330-202 -3435

PROTECTED HEALTH INFORMATION TO BE DISCLOSED:

_____ I authorize ALL information in my medical record to be disclosed according to the terms of this authorization.

FOR THE PURPOSE OF: Continued care _____ Personal use_____ Other _____

This authorization shall be in full force and effect for (60) sixty days from the date of the signing, at which time this authorization shall expire. My permission is extended only for the purpose as stated on this is authorization and I understand that I have the right to revoke this authorization, in writing, any time by sending such written notification to Comprehensive Internal Medicine, at 3727 Friendsville Road, Suite2, Wooster, Ohio 44691. I understand that a revocation is not effective to the extent that Comprehensive Internal Medicine has relied on the use or disclosure of the protected health information. I understand that I will be responsible for any charges incurred for the copying and or faxing of my medical record as permitted by law. _____ (initial) I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. If Comprehensive Internal Medicine is receiving the information, Comprehensive Internal Medicine will only use or disclose information as permitted by law or as authorized by you. Comprehensive Internal Medicine will not condition my treatment on whether I provide authorization for the requested use or protected health information to be used or disclosed as permitted under law.

Signature of patient or Guardian: _____ Date: _____ / ____ / _____