Patient Registration

(Please complete all information)

Patient Name _____

Date of Birth _____Age _____Sex_____

Social Security #_____Marital Status _____

Driver's License #_____Expiration Date _____State _____

Address _____

_____

Phone# Home _____Cell _____Work _____

Pharmacy Name _____

Patient's Employer _____

Insurance Carrier_____

Policy Number_____

Group Number _____

Policy Holder's Name _____

Policy Holder's Relationship to Patient_____

Policy Holder's Date of Birth_____

Policy Holder's Social Security # _____

Policy Holder's Employer _____

Emergency Contacts Not Living With You:

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

Patient Medical Information

Patient Name _____Date of Birth _____

Allergies: Food ____Drug ____Other____ Please List:_____

_____

Physicians (previous/current) _____

_____

Previous/Other Medical Problems _____

_____

_____

Current Medications and Dosage _____

_____

_____

_____

_____

Please List Hospitalizations and Surgeries

Reason for Hospitalization or Type of Surgery	Where	When	Physician

Family History

Living Age / Health Problems	Deceased Age / Health Problems	Has Any Blood Relative Ever Had:	Please Circle		Who
Father		Cancer	No	Yes	
Mother		Tuberculosis	No	Yes	
Siblings 1.		Diabetes	No	Yes	
2.		Heart Trouble	No	Yes	
3.		High Blood Pressure	No	Yes	
4.		Stroke	No	Yes	
5.		Epilepsy	No	Yes	
6.		Mental Illness	No	Yes	
Spouse		Suicide	No	Yes	
Children 1.		Depression	No	Yes	
2.		Thyroid Disease	No	Yes	
3.		Arthritis	No	Yes	
4.		Other			
5.					
6.					

Review of Systems (Please check the following for symptoms <u>now present</u>)

Patient Name (**please print**) _____ DOB _____Date_____

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Excessive Fatigue
- ☐ Unintentional Weight Gain
- ☐ Unintentional Weight Loss
- ☐ Other _____

Eyes:
- ☐ Use Glasses/Contacts
- ☐ Blurry Vision
- ☐ Eye Pain
- ☐ Pain Looking at Bright Lights
- ☐ Other _____

Ear/Nose/Throat:
- ☐ Hearing Problems
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Runny Nose
- ☐ Nose Bleeds
- ☐ Mouth Sores
- ☐ Tooth Pain
- ☐ Sore Throat
- ☐ Voice Change
- ☐ Other _____

Cardiovascular:
- ☐ Chest Pain at Rest
- ☐ Chest Pain with Exertion
- ☐ Heart Fluttering
- ☐ Swollen feet or ankles
- ☐ Other _____

Respiratory:
- ☐ Recent Cough
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Pain with Breathing
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Other _____

Gastrointestinal:
- ☐ Abdomen Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Loss of appetite
- ☐ Heartburn/Acid Reflux
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Other _____

Genitourinary:
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Difficulty Controlling Urine
- ☐ Painful Menses
- ☐ Irregular Menstrual Cycle
- ☐ Heavy Menstrual Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Post-Menopausal Vaginal Bleeding
- ☐ Other _____

Musculoskeletal:
- ☐ New Joint Pains
- ☐ Joint Stiffness
- ☐ Back Pain
- ☐ Muscle Aches
- ☐ Other _____

Skin/Breast:
- ☐ Rashes
- ☐ Unusual Moles
- ☐ Breast Changes
- ☐ Other _____

Neurologic:
- ☐ Headaches
- ☐ Dizziness
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Loss of Coordination
- ☐ Fainting
- ☐ Seizures
- ☐ Tremor
- ☐ Memory Loss
- ☐ Other _____

Blood/Lymphatic:
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Swelling at the Neck
- ☐ Other _____

Endocrine:
- ☐ Difficulty Maintaining a Comfortable Temperature
- ☐ Hot Flashes
- ☐ Excessive Sweating
- ☐ Changing Skin Color
- ☐ Hair loss
- ☐ Infertility
- ☐ Other _____

Allergic/Immunologic:
- ☐ Seasonal Allergies
- ☐ Hives
- ☐ Other _____

Psychiatric:
- ☐ Excessive Sadness
- ☐ Excessive Stress/Anxiety
- ☐ Mood Swings
- ☐ Poor Concentration
- ☐ Significant Trouble Sleeping
- ☐ Suicidal Thoughts
- ☐ Other _____

Social:

Do you smoke_____ Packs per day_____ # of years_____

Do you drink alcohol_____ Drinks per week_____ # of years _____

How many cups of caffeine (coffee/tea/soda) do you drink each day _____

What physical exercise or sports do you participate in regularly_____

Generations Primary Care, PSC Financial Policy

Generations Primary Care, PSC is committed to meeting your health care needs. We are pleased that you have chosen us. Our goal is to provide the very best possible care for you. We have prepared this information regarding our services and fees to help keep your insurance or other financial arrangements as simple as possible. We ask that you adhere to the following guidelines:

- It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit,

- All co-payments are due at the time of service.

- You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank may result in a $25,00 returned check charge.

- It is your responsibility to contact your insurance carrier to confirm that our physicians and nurse practitioners participate in your insurance plan. If you see a provider that is not currently on your plan, you will be responsible for payment in full.

- It is your responsibility to provide a 24-hour appointment cancellation notice. If you miss your appointment and fail to contact our office then a "NO SHOW" fee will be applied to your account. "NO SHOW" charges are considered non-covered services therefore your insurance carrier will not pay this fee; this charge will be billed directly to you.

- Long distance phone calls to patients, on behalf of patients, or to their pharmacy could be assessed a $5.00 charge per call.

- You will be responsible for all non-covered services that your insurance carrier denies for payment.

I understand regardless of any insurance coverage I may have, I understand I am responsible for any outstanding balance due. If I am covered by an insurance plan that my provider participates with, I agree to pay my co-pay or deductible at the time of service and I authorize payment of medical benefits to the provider. If I am covered by an insurance plan that my provider does not participate with, or if I have no health insurance coverage, I agree to payment in full at the time of service. In the event of default in payment, I agree to pay reasonable collection fees, including a reasonable attorney's fee.

Patient Name _____
(Please Print)

Guarantor Signature _____Date _____

Patient Authorization for Personal Representative

Purpose of request -1 authorize Generations Primary Care, PSC to disclose or provide all of my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

Expirations or termination of authorization - Right to revoke or terminate – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) or legal entity authorized to do so by court order or law. As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Redisclosure - We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Generations Primary Care, PSC.

Patient Name _____Date _____

Patient Signature _____

Personal Representative Name _____

Address _____

Phone Number _____

Consent for Blood Sample and Testing

I give consent that in the event an employee of Generations Primary Care, PSC should be exposed to my blood a sample of my blood will be tested for hepatitis B, hepatitis C and HIV. I understand that the blood sample will be sent out to a laboratory for testing, and that the test results will be released directly to the exposed employee. I further understand that the test results will NOT be released to any other individual in the practice, including owners, physicians, management and other employees. The exposed employee will hold the test results confidential; consulting only with the healthcare professional that is conducting the follow-up evaluation for the incident. Generations Primary Care, PSC will absorb the cost for the testing.

Patient Name _____Date of Birth _____

Signature_____Date _____

GENERATIONS
Primary Care
270 Burley Avenue ♦ Hopkinsville ♦ KY ♦ 42240
Telephone: 270-887-6767 ♦ Fax: 270-887-6161

Patient Portal/Patient-Provider E-mail
Authorization to Use or Disclose Protected Health Information via Electronic Media

Patient Name _____ Date of Birth_____

Email Address_____
(Please print legibly)

By signing this form, I authorize Generations Primary Care (GPC) to communicate via personal, secured access patient portal with me for my medical care and treatment. GPC will provide notices via my personal email that information can be found in my patient portal. No personal health information is transmitted via or into my personal email. I understand that the following types of protected health information (PHI) may be used, disclosed and retained by the healthcare providers of GPC as a result of the communications:

1. My personal health information
2. Electronic displays of radiological images (x-rays)
3. Laboratory test results
4. Pathology reports
5. Other diagnostic test results

Patients and /or personal representatives who want to communicate with their healthcare provider by clinic portal should consider all of the following issues before signing this authorization:

1. Portal communication is a convenience and not appropriate for emergencies or time sensitive issues.
2. Portal messages received at GPC can be forwarded, printed and /or read, stored by GPC staff members.
3. We advise caution when communicating highly sensitive or personal information via portal messages (i.e. HIV status, mental illness, chemical dependency, and worker compensations issues)
4. Clinically relevant messages and responses will be documented in the medical record.
5. GPC will not be liable for information lost or misdirected due to technical errors or failures.
6. GPC does not own or have any interest in the portal website. E-MDS portal is a secure conduit in which communication with our database is managed.

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing and address it to Generations Primary Care. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization. I understand that I may refuse to sign this authorization. I also understand that Generations Primary Care cannot deny or refuse to provide treatment, payment or medical records if I refuse to sign this authorization.

I have read and understand the information in this authorization form.

Signature_____Date_____

GENERATIONS
Primary Care
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Patient Authorization for Disclosure to Designated Provider
Authorization to Release Medical Record Information

Provider: _____Patient SS#: _____

Patient Name (please print): _____ DOB: _____

Purpose of Request - I request and authorize the disclosure or release of my protected health information (as identified below) TO/FROM (circle one) following provider:

Name of practice: _____

Name of provider: _____

Address: _____

City, State, Zip: _____

Phone: _____

Description of information to be disclosed – I authorize the disclosure of the following protected health information about me to the person(s) identified above.

_____ Complete medical record (to include any and all information regarding HIV (aids) and testing, sexual abuse, spouse or child abuse, mental illness and substance abuse including controlled substance or alcohol abuse): or

_____ Only the following information: _____

_____

Purpose of disclosure – This protected health information is being used or disclosed to carry out treatment, payment and/or healthcare operations in the following manner:

Expirations or termination of authorization – This authorization will expire within _____ days from the date of my signature below.

_____ _____
Patient Signature Date

_____ _____
Signature of Authorized Person Relationship to Patient

_____
For Office Use Only

Date records received _____ Employee initials _____
Date mailed _____ Employee initials _____