PATIENT REGISTRATION

____ ______________

Last Name First Name Middle Initial Race

____

SSN Driver's Lic# Birth Date Age Gender (M/F)

Mailing Address:___________________________ Home Address:___________________________

____ ____

____ ____

Home Phone:_________________ Day Phone:___________________Cell Phone: ___________________

E-Mail Address____________________________

How should we contact you for Preventive Care Reminders? ______________________________________

EMERGENCY INFORMATION:

____

Emergency Contact Name Relationship Phone #

____

Spouse/Parent/Guardian's Name Address if different Phone #

EMPLOYMENT INFORMATION:

____

Employer

____

Address Phone #

____

Spouses Employer

____

Address Phone #

How did you hear about our clinic? ____

NATIVE AMERICAN PATIENTS PLEASE PROVIDE US WITH YOUR TRIBAL AFFILIATION OR ENROLLMENT PAPERWORK. IF YOU DO NOT HAVE THIS INFORMATION, PLEASE ADVISE THE RECEPTIONIST

<u>CONTINUED ON REVERSE</u>

Please note ALL questions must be answered in order to serve you better.

PATIENT REGISTRATION

PRIMARY INSURANCE INFORMATION:

Name of Insured	Date of Birth	Your relationship to Insured

Insurance Carrier	ID#	Group #

Insurance Mailing Address

SECONDARY INSURANCE INFORMATION:

Name of Insured	Date of Birth	Your relationship to Insured

Insurance Carrier	ID#	Group #

Insurance Mailing Address

Authorization to release information for billing purposes and assignment of payment benefits to Mathiesen Memorial Health Clinic (MMHC)

I, the undersigned, am requesting health care services from the personnel at MMHC. I consent to exams, tests, immunizations, and treatment felt necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I understand that in the event the insurance information is not complete and correct, or if my insurance carrier fails to make payment, I will be financially responsible for services rendered. I authorize the release of any information required by my insurance company to process any claims. I further authorized assignment of all insurance benefits directly to MMHC.

______________________________________ ____________________

Signature of Patient/Parent/Guardian Date

PATIENT REGISTRATION

WELCOME

To Mathiesen Memorial Health Clinic
This is our self administered health history form.

Thanks for taking time to fill this out. It goes into the computer as part of your record and can protect you from drug interactions and other kinds of harm.

What is the main reason you are looking for a Medical Provider.

____

____

____

Recent or important past Medical Providers

____

____

____

____

____

Overall what are your chronic ongoing medical issues, like back pain, diabetes, contraception, etc?

Chronic and ongoing Medical issues	When, how it started?, comments
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
For additional chronic medical issues see back of page	

Do you have past health issues that have been resolved?

Past Medical Issues	How resolved, comments
1.	
2.	
3.	
For additional past medical issues see back of page	

PATIENT REGISTRATION

Please list all prescription medication including dose, amount and prescribing physician

MEDICINE	Dose (usually mg.)	How many x A day ?	Who prescribed it, when started	Reason taken
See back of page to add more medicines				

Do you take non prescription medicine and/or herbs and supplements?

What is it?	Dose if known	How many daily	Reason taken

Alcohol: I drink alcohol Yes_______NO_________Pattern of use_________________

Alcohol has caused me problems or my family complains about my drinking Yes_____No________

I no longer drink because

____

____

I use drugs now or my family complains about my drug use Yes________No___________

Drugs have been a problem for me in the past___________________________________

I have used injection drugs or cocaine straws in the past (risk of hepatitis C) Yes______No______

Signature and date REQUIRED

Signature____DATE ____________________________