ADVANCED HEALTH
& WELLNESS

900 Biddle Road
Medford, OR 97504
Phone: (541)-414-0481
Fax: (541) 414-0482

Patient Registration (Please print clearly)

Last Name:_____First:_____Middle:_____

Preferred Name:_____Date of Birth:_____Gender: Male__Female__

SS#:_____Pharmacy & Location:_____

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Decline to answer

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status:

☐ Single ☐ Married ☐ Divorced

Driver's License #:_____

Home Address:_____City:_____State:_____Zip:_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____Primary Phone: Home Work Cell Appt. Reminders OK? Yes No

Emergency Contact:_____Phone:_____Relationship:_____

Emergency Contact:_____Phone:_____Relationship:_____

Employer:_____Phone:_____Occupation:_____

If patient is a minor:

Mother:_____DOB:_____Phone:_____

Father:_____DOB:_____Phone:_____

Insurance Information

Primary Insurance:_____Policy #:_____Group #:_____

Policy Holder:_____DOB:_____SSN:_____Relationship:_____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Advanced Health & Wellness to provide my insurance companies with all information necessary to process insurance claims and assign payments to Advanced Health & Wellness all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature:_____ Date:_____

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Health History

Name_____Date of birth_____

Medical History (circle below if you have had any of the following):

Allergies/Hay Fever	Artery Blockage	Fatigue	Anemia	DVT
Glaucoma	High Blood Pressure	Fibromyalgia	HIV/AIDS	Anxiety
Hearing Loss	High Cholesterol	Thyroid Problems	Arthritis	Bipolar Disorder
Rhinitis	Palpitations	Diverticulitis	Back Pain	Depression
Visual Loss	Vascular Disease	Hepatitis	Sciatic Pain	Anxiety
Breast Lump	Stroke	Hernia	Joint Pain	Asthma
Breast Cancer	Eczema	Spastic Colon	Epilepsy	COPD/Emphysema
Arrhythmia	Skin Cancer	Ulcer	Meningitis	Pneumonia
Heart Attack	Skin Problems	Reflux	Migraine	Tuberculosis
Heart Murmur	Diabetes	Abnormal Periods	Edema	Bladder/Kidney Infection

Other problems not listed_____

_____

Have you had cancer (list type and treatment)_____

_____

Have you had any of the tests below:

	Date	Reason	Where was the test done?
Heart Test			
Ultrasound			
CT Scan			
MRI			
Bone Density			
Colonoscopy			
Sigmoidoscopy			
Mammogram			

Past surgical history (include date or age you had the surgery):

Date	Surgery	Surgeon

List all medications, vitamins, supplements, over the counter medications (with dosage):

☐ I don't take medication

Name of Medication	Dosage	Directions

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List all allergies (medications, environmental, and food):

Medication	Reaction	Environmental or food	Reaction

Vaccinations (date of last):

Tetanus/Tdap_____Flu_____Pneumonia_____Shingles_____

Family medical history:

	Medical problems	Living or deceased	Age at death
Father			
Mother			
Sibling			
Sibling			
Other			

Social history:

Present occupation_____Past occupation_____Highest level of education_____

Have you served in the military_____Places you have lived_____

Religious preference_____Is faith important to your health_____

Do you consume alcohol_____Last drink_____

How many drinks a week_____

Do you or have you use(d) recreational drugs_____What drugs_____

Do you or have you smoke(d)_____Age started_____Age quit_____Packs per day_____

Do you exercise_____How often_____What type of exercise_____

Do you have any of the following symptoms (circle all that apply if you have any of the following):

Weight Gain	Ringing in Ears	Short of Breath	Bloody Urine	Muscle Pain/Weakness
Weight Loss	Deafness	Poor Appetite	Frequent Urination	Memory Problems
Night Sweats	Sinus Problems	Abdominal Pain	Painful Urination	Back Pain
Fever/Chills	Cough	Nausea/Vomiting	Sexual Problems	Joint Pain/Swelling
Headaches	Irregular Heart Beat	Diarrhea	Rash	Change in Energy
Visual Changes	Chest Pain	Constipation	Skin Changes	Depression
Dizzy/Vertigo	Palpitations	Changes in Bowel Habits	Fainting	Anxiety
Earache	Swelling	Heartburn	Seizures	Trouble Sleeping
Allergies	Wheezing	Impotence	Numbness	Thoughts of Suicide

Women:

Number of pregnancies_____Deliveries_____Miscarriages_____Abortions_____Ectopic pregnancies_____

Age menses started_____Age menses stopped_____Last period_____Last PAP smear_____

Do you have:

Painful periods_____Pain with sex_____Irregular periods_____Problems getting pregnant_____

Are you sexually active_____Using any type of birth control_____

What birth control have you used in the past_____

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Consent to Release Protected Health Information

Patient Name_____Date of Birth_____

Consent

I request Advanced Health & Wellness to release protected healthcare information to:

Name_____

Relationship to Patient_____Phone #_____

Name_____

Relationship to Patient_____Phone #_____

Name_____

Relationship to Patient_____Phone #_____

This request and authorization applies to: (please check below)

☐ All healthcare information (Medical and Billing)

☐ Healthcare information relating to the following treatment, condition or dates:

_____

_____

☐ Other_____

I understand that this designation applies only to Advanced Health& Wellness.

Patient Signature_____ Date Signed_____

Revocation/Termination

I request to revoke/terminate the designation made above.

Patient Signature_____ Date Signed_____

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Authorization to Use and Disclose Health Information

I hereby authorize (previous healthcare provider):	To disclose to:
Name of disclosing party	Name of Recipient
Address	Address
City, State Zip	City, State Zip
Phone Fax	Phone Fax

Records and information pertaining to:

Patient name (list other names used) SS# Date of Birth

Address Phone number

For the purpose of:_____

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here_____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial to specify which type of information is to be disclosed, and then sign and date.

☐ Medical information _____ (initials) ☐ Psychiatric information _____ (initials)

☐ Drug/Alcohol Information _____ (initials) ☐ Results of HIV Test _____ (initials)

☐ Genetic Records _____ (initials)

Signature:_____Date:_____

A copy of this authorization is as valid as the original.

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Acknowledgment of Receipt of Notice of Privacy Practices

I, (print patient name), acknowledge and agree that I have received a copy of Advanced Health & Wellness Notice of Privacy Practices.

Patient signature_____Date_____

Patient legal representative signature_____Date_____

Print name of legal representative_____

Relationship to patient_____

FOR CLINIC USE ONLY

Advanced Health & Wellness made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices.

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

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Appointment Cancellation and No-Show Policy

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** will be considered a NO SHOW.
- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** a second time will be charged a **$50.00** fee.
- If a third No Show or cancellation/reschedule with no **24-hour notice** should occur the patient may be **dismissed** from our practice.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- If you are late for an appointment you may have to reschedule your appointment. Please be 15 minutes early for your appointment so we can take care of administration tasks.
- As a courtesy, when time allows, we make reminder calls for appointments.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office immediately. Our provider will be notified and we might be able to waive the No Show fee. You can leave a message on our answering machine 24 hours a day, 7 days a week.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____
Signature (Patient/Parent/Legal Guardian)	Relationship to Patient (self, parent, etc.)
_____	_____
Print Name (Patient/Parent/Legal Guardian)	Date