# Patient Registration Form

Print out this form and also the Health History Form. Bring both fully completed forms and your insurance card with you and give them to our staff as you check in for your appointment.

Patients Name_____

Insurance policy holders name and Social security number _____

Address _____

Home Phone number _____

Work Phone Number _____

Emergency contact – (relationship, name and phone number)_____

Name of insurance company

_____

___HMO ___PPO ____POS

Group number_____ Plan number_____

Do you have a copay? ____ IF so how much?_____

**HEALTH HISTORY - Please bring this form with you to your appointment or you will be asked to complete another.**

Name _____ Today's Date _____

Age _____ Birth date _____Date of last physical exam _____

Are you presently under a physician's care for any condition? Yes No

If yes, please state condition _____ Name of Physician _____

## Symptom Check (√) Symptoms You Have Currently Or Have Had In The Past Year

ÿ CONSTITUTIONAL
ÿ Chills
ÿ Fainting
ÿ Fever
ÿ Loss of sleep
ÿ Loss of weight
ÿ Nervousness
ÿ Sweats

ÿ EARS, NOSE, THROAT, MOUTH
ÿ Bleeding gums
ÿ Difficulty swallowing
ÿ Earache
ÿ Ear discharge
ÿ Hoarseness
ÿ Loss of hearing
ÿ Nosebleeds
ÿ Ringing in ears
ÿ Sinus problems

ÿ EYES
ÿ Blurred vision
ÿ Crossed eyes
ÿ Double vision
ÿ Redness
ÿ Visual flashes/halos
ÿ Watering

ÿ ALLERGIC/IMMUNOLOGIC
ÿ Hay Fever

ÿ HEMATOLOGIC
ÿ Bleeding disorders

ÿ SKIN
ÿ Bruise easily
ÿ Change in moles
ÿ Hives
ÿ Itching
ÿ Jaundice
ÿ Rash
ÿ Scars
ÿ Sore won't heal

ÿ CARDIOVASCULAR
ÿ Chest pain
ÿ Irregular heart beat
ÿ High blood pressure
ÿ Low blood pressure
ÿ Poor circulation
ÿ Rapid heart beat
ÿ Swelling of ankles
ÿ Varicose veins

ÿ NEUROLOGICAL
ÿ Dizziness
ÿ Falling
ÿ Forgetfulness
ÿ Headache
ÿ Loss of consciousness
ÿ Numbness Location
_____
ÿ Seizures
ÿ Shaking

ÿ GENITO-URINARY
ÿ Blood in urine
ÿ Frequent urination
ÿ Lack of bladder control
ÿ Painful ruination
ÿ Urgency

ÿ GU: MALES
ÿ Discharge
ÿ Testicular mass
ÿ Testicular tenderness

ÿ GU: FEMALES
ÿ Bleeding between periods
ÿ Breast lump
ÿ Extreme menstrual pain
ÿ Hot flashes
ÿ Nipple discharge
ÿ Painful intercourse
ÿ Vaginal discharge
ÿ Date of last menstrual period
_____
ÿ Pads/tampons per day
_____
ÿ Douche: Yes No
ÿ Date of last PAP smear
_____
ÿ Normal Abnormal
ÿ Are you pregnant? Yes No
ÿ Number of children _____
ÿ Date of last mammogram
_____

ÿ ENDOCRINE
ÿ Cold intolerance
ÿ Excessive hunger
ÿ Excessive thirst
ÿ Goiter
ÿ Growth changes

ÿ RESPIRATORY
ÿ Asthma
ÿ Coughing up blood
ÿ Difficulty breathing
ÿ Persistent cough
ÿ Wheezing

ÿ MUSCLE/JOINT/BONE
ÿ Pain, weakness, numbness in:
ÿ Arms Hips
ÿ Back Legs
ÿ Feet Neck
ÿ Hands Shoulders
ÿ Fracture _____

ÿ GASTROINTESTINAL
ÿ Appetite poor
ÿ Bloating
ÿ Bowel habit changes
ÿ Constipation
ÿ Diarrhea
ÿ Gas
ÿ Heartburn
ÿ Hemorrhoids
ÿ Indigestion
ÿ Nausea
ÿ Rectal Bleeding
ÿ Stomach pain
ÿ Vomiting
ÿ Vomiting blood

ÿ OTHER (Please list)
_____
_____
_____
_____
_____

## Conditions Check (√) Conditions You Have Or Have Had In The Past

| | | | | | |
|---|---|---|---|---|---|
| ÿ Abnormal PAP | ÿ Breast lump | ÿ Glaucoma | ÿ High blood pressure | ÿ Pacemaker | ÿ Thyroid problems |
| ÿ AIDS | ÿ Bronchitis | ÿ Goiter | ÿ High cholesterol | ÿ Pneumonia | ÿ Tonsillitis |
| ÿ Alcoholism | ÿ Bulimia | ÿ Gonorrhea | ÿ HIV Positive | ÿ Polio | ÿ Tuberculosis |
| ÿ Anemia | ÿ Cancer | ÿ Gout | ÿ Irregular periods | ÿ Prostatis | ÿ Ulcers |
| ÿ Angina | ÿ Cataracts | ÿ Heart disease | ÿ Kidney disease | ÿ Psychiatric care | ÿ Urethral dis/inf |
| ÿ Anorexia | ÿ Chem. Dependency | ÿ Headaches | ÿ Liver disease | ÿ Rheumatic fever | ÿ Vaginal infections |
| ÿ Arthritis | ÿ Diabetes | ÿ Hernia | ÿ Migraines | ÿ Sexual Tras.Disease | ÿ Other (list) |
| ÿ Asthma | ÿ Emphysema | ÿ Herpes | ÿ Miscarriage | ÿ Stroke | |
| ÿ Bleeding disorders | ÿ Epilepsy | ÿ Hepatitis | ÿ Multiple sclerosis | ÿ Suicide attempt | |

## Medications List Medications You Are Currently Taking (Include Dosage)

| | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | |
| 4. | 7. |
| Pharmacy Name | Phone Number |

**HEALTH HISTORY**

| Allergies Or Adverse Reactions To Medications Or Substances | | |
|---|---|---|
| 1 | 2 | 3 |
| | | |

**Family History Complete Health Information about Your Family**

| Relation | Age | State of health | Age at death | Cause of death | Check (√) if your blood relatives had any of the following: (√) Disease | Relationship |
|---|---|---|---|---|---|---|
| Father | | | | | Arthritis, Gout | |
| Mother | | | | | Asthma, Hay fever | |
| Brothers | | | | | Cancer, Type | |
| | | | | | Chemical dependency | |
| | | | | | Diabetes | |
| Sisters | | | | | High blood pressure, stoke | |
| | | | | | Heart disease | |
| | | | | | Kidney disease | |
| Grandparents | | | | | | |

**Surgeries/Hospitalizations**

| Year | Hospital | Reason for surgery/hospitalization |
|---|---|---|
| | | |
| | | |
| | | |

**Pregnancy History (Including miscarriages, abortions, etc.)**

| Year of Birth | Sex of Birth | Complication, if any |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? Yes No
If yes, please give approximate date(s) _____

**Health Habits (√) Which Substances You Use And Describe How Much You Use And/Or How Often Habit Is Engaged In.**

| Serious Illness/Injuries | Date | Outcome | | | | |
|---|---|---|---|---|---|---|
| | | | | Caffeine | | |
| | | | | Alcohol | | |
| | | | | Drugs | | |
| | | | | Tobacco (packs per day) | | |
| | | | | Seatbelts | | |
| Occupations Concerns Check (√) if your work exposes you to the following | | | | Exercise | | |
| Stress | | | | Self breast exam | | |
| Hazardous Substances | | | | Self testicular exam | | |
| Heavy Lifting | | | Do you feel safe at home? | | Yes | No |
| Other | | | Are you sexually active? | | Yes | No |
| What is your Occupation? | | | Are you on birth control? If yes, what type | | Yes | No |

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

_____ _____
Signature of patient Date

_____ _____
Signature of Physician/Nurse Practitioner Date

# Encompass Medical Group

**Notice of Privacy Practices**
**Understanding Your Health Record Information**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

**Our Pledge Regarding Your Health Information:** We understand that information about you and your health is personal. We are committed to protecting the privacy of this information. Each time you visit Encompass Medical Group we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Encompass Medical Group whether made by health care personnel or your physician.

**Our Responsibilities**: Our primary responsibility is to safeguard your personal health information. We must also give you this notice of our privacy practices, and we must follow the terms of the notice that is currently in effect.

**Changes To This Notice:** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will have available in our facilities a copy of this notice and it will also be posted on our web site at www.encompassmed.com.

**You Have the Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer at (913) 495-2200. There will be no retaliation for filing a complaint. You have the right to complain to the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, Phone (202) 619-0257.

**How We May Use & Disclose Health Information About You**: The following categories describe different ways that we use your health information within Encompass Medical Group and disclose your health information to persons and entities outside of Encompass Medical Group. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories.

**With Your Written Acknowledgement of Our Information Privacy Practices:** In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), we will obtain in writing your acknowledgement of receipt of our Notice Of Privacy Practices when you first visit Encompass Medical Group. The Notice of Privacy Practice and the Acknowledgment of Receipt are necessary to allow us to use your health information within Encompass Medical Group and to disclose your health information outside of Encompass Medical Group. **TREATMENT** – We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us. **PAYMENT** – We may use and disclose health information about you so the treatment and services you receive at our health care facility may be billed to and payment collected from you, an insurance company, or third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from your insurance plan. **HEALTH CARE OPERATIONS –** We may use and disclose health information about you for health care operations, including quality assurance activities; granting medical staff credentials to physicians; administrative activities, including Encompass Medical Group financial and business planning and development; customer service activities, including investigation of complaints, and certain marketing activities. These uses and disclosures are necessary to operate our health care facility and make sure all of our patients receive quality care. **BUSINESS ASSOCIATES** – There are some services provided in our organization through contracts with business associates. Examples of business associates include accreditation agencies, management consultants, quality assurance reviewers, etc. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, we require business associates to sign a contract that states they will appropriately safeguard your information.

**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care at our health care facility. **MARKETING** – We may contact you as part of a marketing effort. As part of our marketing, we may tell you about Encompass Medical Group's health-related products and services that may be of interest to you.

**With Your Verbal Agreement – Individuals Involved in Care/Payment:** We may disclose health information about you to a friend or family member, who is involved in your medical care, unless you tell us in advance not to do so. In addition, we may disclose health information about you to an entity assisting in disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status and location.

**With Your Specific Written Authorization:** Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission (called "authorization"). If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Some typical disclosures that require your authorization are as follows:

**With Your Written Consent – Research Unrelated to Treatment:** When a research study does not involve any treatment, we may disclose your health information to researchers when an Institutional Review Board (IRB) has reviewed the research proposal, has established appropriate protocols to ensure the privacy of your health information, and has approved the research.

**Research Involving Treatment:** When a research study involves your treatment, we may disclose your health information to researchers only after you have signed a specific written authorization. In addition, for any such research study, an Institutional Review Board (IRB) will already have reviewed the research proposal, established appropriate protocols to ensure the privacy of your health information, and approved the research. You do not have to sign the authorization in order to get treatment from Encompass Medical Group, but if you do refuse to sign the authorization, you cannot be part of the research study.

**Drug & Alcohol Abuse:** We will disclose drug and alcohol treatment information about you only in accordance with the federal Privacy Act. In general, the Privacy Act requires your written authorization for such disclosures.

**Disclosure of Mental Health Information:** We will disclose mental health treatment information about you only in accordance with state law. In most cases, state law requires your written authorization or the written authorization of your representative for such disclosures.

**Special Situations That Do Not Require Your Information Consent or Authorization:** The following disclosures of your health information are permitted by law without any oral or written permission from you; **ORGAN AND TISSUE DONATION** – If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation. **MILITARY AND VETERANS** – If you are a member of the armed forces, we may release health information about you as required by military command authorities. **WORKER'S COMPENSATION** - We may release health information about you for worker's compensation or similar programs if you have a work related injuries. These programs provide benefits for work related injuries. **AVERTING SERIOUS THREAT** – We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability.
- To report births and death.
- To report child abuse or neglect.
- To report reactions to medications, problems with products or other adverse events.
- To notify people of recall of product they may be using.
- To notify a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including elder abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Lawsuits & Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena; discovery request or other lawful process by someone else involved in the dispute.

**Law Enforcement:** We may disclose health information if asked to do so by law enforcement officials for the following reasons: 1. In response to a court order, subpoena, warrant, summons or similar process. 2. To identify or locate a suspect, fugitive, material witness or missing person. 3. About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement. 4. About a death we believe may be the result of a criminal conduct. 5. About criminal conduct at our facility. In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners & Medical Examiners:** We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death of a person. We may also release health information about patients at our facility to funeral home directors as necessary to carry out their duties.

**National Security**: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

**Inmates:** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with health care, to protect your health and safety and the health and safety of others, or for the safety and security of the correctional institution.

**Required by Law:** We will disclose health information about you without your permission when required to do so by federal, state or local law.

**Your Health Information Rights.** Although your health record is the physical property of Encompass Medical Group, the information belongs to you.

**YOU HAVE THE RIGHT TO: Restriction –** Request a restriction on certain uses and disclosures of your information. We are not required by law to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. **Inspect –** Inspect and request a copy of your health record for a fee. We may deny your request under very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed by another health care professional chosen by someone on our health care team. We will abide by the outcome of that review. **Amend** – Request an amendment to your health record if you feel the information is incorrect or incomplete. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. Also, we may deny your request if the information was not created by our health care team, is not part of the information kept by our facility, is not part of the information which you would be permitted to inspect and copy, and if the information is accurate and complete. Please note that even if we accept your request, we are not required to delete any information from your health care. **Accounting** – Obtain an accounting of disclosures of your health information. The accounting will only provide information about disclosures made for purposes other than treatment, payment or health care operations, or for anything you have authorized. **Confidential** – Request communication of your health information by alternative means or locations. **Revocation –** Revoke your authorization to use or disclose health information except to the extent that action has already been taken.