# Woodbury Medical Center

## REGISTRATION FORM

Date ______________________ How did you hear about our office? ______________________

## 1 Patient Information:

Patient Name ______________________

Date of Birth ______________ Male _______ Female _______ Social Security Number ______________

Address ______________________

City ______________________ State ________ Zip ________

Home Telephone Number ______________________ Cell/Alternate # ______________________

Marital Status Single_______ Married _______ Separated _______ Divorced _______ Widowed _______

Employer's Name ______________________ Work Number ______________

Employer's Address ______________________

Where do you prefer to receive calls? Home_______ Cell_______ May we leave information on your voicemail? ____Y ____N

Pharmacy Name ______________________ Telephone Number______________

Address ______________________

City ______________________ State ________ Zip ________

WHO MAY WE SPEAK TO REGARDING YOUR PERSONAL HEALTH INFORMATION

______________________ Relationship______________ Phone ______________

______________________ Relationship______________ Phone ______________

## 2 Emergency Contact Information:

Name ______________________ Relationship to Patient ______________

Telephone Number______________________ Cell Number______________________

## 3 Patient Portal:

This makes communication between you and your provider much easier. With the portal, you can safely view your results and messages, as well as send messages online.

**WOULD YOU LIKE TO USE OUR PATIENT PORTAL:** _______ Yes _______ No

If yes, please provide your email address:

______________________

Once your portal account is created, a username and temporary password will be sent to your email. You will need to log in to your portal account to activate and receive/send messages and results.

PLEASE TURN OVER

## 4 Billing Information: (who will pay for services NOT covered by insurance)

Name ____________________ Relationship to Patient ____________________

Address ________________________________________

Date of Birth ____________________ Social Security # ____________________

Telephone Number ____________________ Alternate Number ____________________

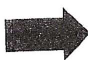
## 5 HIPAA Acknowledgment:

**Patient Name:** ____________________ **DOB:** ____________________

**I have:**

**( ) Taken a HIPAA Notice of Privacy Practices for my records**

**( ) I have been offered a Notice of Privacy Practices, but declined**



**Sign Here** ____________________ **Patient's Signature** ____________________ **Date Signed**

## 6 Insurance Information: (Please provide insurance card(s))

**Primary Insurance** ________________________________________

ID # ____________________ Group # ____________________

Insured's Name ____________________ Insured's Date of Birth ____________________

Insured's Employer ____________________ Insured's Social Security # ____________________

Relationship to Patient Self ________ Spouse ________ Child ________

**Secondary Insurance** ________________________________________

ID # ____________________ Group # ____________________

Insured's Name ____________________ Insured's Date of Birth ____________________

Insured's Employer ____________________ Insured's Social Security # ____________________

Relationship to Patient Self ________ Spouse ________ Child ________

***I hereby authorize release of any information, including the diagnosis and record of any treatment or examination rendered to me or my dependent, during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay benefits otherwise payable to me, directly to Woodbury Medical Center. I understand that my insurance carrier may pay less than the actual bill for services. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON BEHALF OF MYSELF OR MY DEPENDENT. THERE IS A $25 FEE FOR ALL MISSED APPOINTMENTS.***

**Sign Here** ____________________ **Patient's Signature (or Legal Guardian if under age of 18)** ____________________ **Date**

# Woodbury Medical Center

## HEALTH QUESTIONNAIRE

Patient Name ______________________________ DOB ______________ Male_____ Female _____

Information is self-reported by Patient or Parent/Guardian. State name of person completing form and relationship to patient:

______________________________________________________________

### GENERAL HEALTH/SAFETY QUESTIONS ABOUT PATIENT (please answer which apply)

Primary language of family members/guardian: ( ) English ( ) Spanish ( ) Other ______________

Highest Grade Completed ____________ College ____________

( ) Public Water Supply ( ) Other Water Supply ( ) Guns in Home ( ) Physical/Sexual Abuse

( ) Wear Seat Belt/Car Seat ( ) Smoke detectors in home ( ) Regular Exercise ( ) Allergies ______________

### TOBACCO USE

( ) Smoke Cigarettes — Packs per Day ______________

( ) Past Smoker — Date Stopped ______________

( ) Chews/Dip — Frequency ______________

( ) Past Chew/Dip — Date Stopped ______________

( ) What year did you start smoking? — Date ______________

( ) Exposure to 2nd Hand Smoke — Where (car, house) ______________

### SUBSTANCE ABUSE

( ) Alcohol How Much, How Often ______________

( ) Drugs (street/IV) How Much, How Often ______________

### VACCINE HISTORY

Last Tetanus: ______________

Flu Vaccine: ______________

Pneumonia Vaccine: Prevnar 13 ______________ Penumovax 23 ______________

MMR: ______________

Hepatitis B: ______________

COVID Vaccine: ______________ Shingles Vaccine: ______________

### FAMILY MEDICAL HISTORY OF PATIENT

Cancer (what type) ______________

Age Diagnosed ______________

Diabetes (type 1 or 2) ______________

Heart Disease/Attack (circle one) ____________ Age ______

High Cholesterol ______________

Stroke ______________

High Blood Pressure ______________

Kidney Disease ______________

Glaucoma ______________

Bleeding Disorder ______________

Mental Illness ______________

Epilepsy/Seizures (circle one) ______________

Other ______________

PLEASE TURN OVER

## MEDICAL HISTORY OF PATIENT (Please check all that apply)

( ) Anemia
( ) Arthritis
( ) Asthma
( ) Blood Clots
( ) Cancer
( ) Colon/Bowel -explain ______
( ) COPD
( ) Depression

( ) Diabetes
( ) Epilepsy/Seizures
( ) Gallbladder
( ) Hearing Impaired
( ) Heart Disease/Attack
( ) High Blood Pressure

( ) HIV/AIDS
( ) Kidney/Bladder -explain ______
( ) Liver Disease/Hepatitis
( ) Mental Illness
( ) Migraine Headaches
( ) Physical Activity Limitations–explain ______

( ) Sexually Transmitted Disease
( ) Shingles
( ) Skin Problems
( ) Stroke
( ) TB

Childhood Diseases ______

Hospitalizations (other than surgeries) ______

Surgeries ______

Other Injuries ______

Specialists you see ______

Last Colon Cancer Screening ______

## FOR CHILDREN UNDER 6 YEARS OF AGE

Birth Weight ______ Birth Length ______ ( ) Vaginal Birth ( ) C-Section ( ) Premature ( <36 weeks)

Pregnancy Complications ______ Delivery Complications ______

Mother's # of Prenatal Visits ______ Hospital Newborn Metabolic Screening ______ Hospital Newborn Hearing Screening ______

Hospital of Birth ______

Length of Hospital Stay ______ Name of Daycare ______

## FOR WOMEN ONLY

Date of Last Period ______ # of Pregnancies ______ # of Live Births ______ Date of Last Delivery ______

Number of C Sections ______ Did Mother take DES Drugs? ______ Date of Last Mammogram ______

Date of Last Pap Smear ______ Abnormal Mammogram in Past (date) ______

Abnormal Pap Smears in Past (date) ______

Hysterectomy ______ If so, was it total? ______

Have you ever had a bone density scan or DEXA? ______

## ADVANCE DIRECTIVES FOR HEALTH CARE (18 and older)

Have you finalized any advanced health directives (living will, durable power of attorney, organ donation, "do not resuscitate" instructions). Yes ______ No ______ Information given to Woodbury Medical Center? ( ) Yes ( ) No

# Woodbury Medical Center

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**(All sections must be completed)**

Patient Name:______________________________ DOB:______________

I hereby authorize______________________________
and its physicians, employees and agents, to release or disclose to the below-named recipient all of my medical records, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Phone #______________________________ Fax #______________________________

Patient Name ______________________________ Date of Birth ______________

I hereby authorize the release of medical records to:

______________________________

Purpose of disclosure______________________________

This authorization will expire on______________________________
(date or event may not exceed one year)

This request and authorization applies to:

______ All medical records

______ Health care information relating to the following treatment, condition, or dates of treatment

______________________________

______________________________

______ Specific records to be released (labs, imaging reports, other)

______________________________

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you DO NOT WANT released.**

______ **Substance abuse** ______ **Psychological or psychiatric treatment** ______ **HIV/AIDS/STD**

**I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.**

**Sign Here**

______________________________ ______________
**Signature of Patient or Authorized Representative** **Date Signed**

______________________________
**Relationship to Patient**