UNIVERSITY CLINICAL HEALTH

PATIENT REGISTRATION FORM

CHART NO: | FOR OFFICE USE ONLY:

MRN: | DATE OF APPT: | CLINIC: | DOCTOR :

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	SEX	DATE OF BIRTH	MARITAL STATUS	RACE	SOCIAL SECURITY NUMBER

PATIENT ADDRESS	CITY,	STATE ZIP	PRIMARY PHONE NUMBER

EMPLOYER ADDRESS	CITY,	STATE ZIP	WORK PHONE NUMBER

PRIMARY CARE PHYSICIAN	ADDRESS	CITY	STATE ZIP	PHONE NUMBER

EMAIL ADDRESS	HOW DID YOU HEAR ABOUT US?

EMPLOYER NAME/SCHOOL NAME

EMERGENCY CONTACT INFORMATION

SPOUSE / GUARDIAN (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER

SPOUSE / GUARDIAN ADDRESS	CITY,	STATE	ZIP	SPOUSE / GUARDIAN PHONE NUMBER

RESPONSIBLE PARTY

GUARANTOR (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP TO PATIENT *SELF* *DEP CHILD* *SPOUSE* *STUDENT* *OTHER*	GUARANTOR SS NUMBER

GUARANTOR ADDRESS	CITY,	STATE	ZIP	PRIMARY PHONE NUMBER

GUARANTOR EMPLOYER

GUARANTOR EMPLOYER ADDRESS	CITY	STATE	ZIP	WORK PHONE NUMBER

INSURANCE INFORMATION

SUBSCRIBER NAME	EXPIRATION DATE	RELATIONSHIP TO INSURED
		SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ FSC# _____ IC# _____ INS # _____

PRIMARY INSURANCE COMPANY	ADDRESS	CITY	STATE	ZIP

GROUP NO. POLICY # ID # OR CERTIFICATE #	EFFECTIVE DATE

SECONDARY INSURANCE COMPANY	ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO INSURED
					SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ INS # _____

GROUP NO. POLICY # ID # OR CERTIFICATE #	EFFECTIVE DATE

IS THIS VISIT RELATED TO AN ACCIDENT | DATE OF INJURY

AUTO *JOB RELATED*

REFERRING PHYSICIAN NAME	ADDRESS	CITY	STATE ZIP	PHONE NUMBER

PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING

PATIENT RESPONSIBILITIES: I understand that as the patient, parent, or guardian, I am legally responsible for payment of all charges relating to my care. Patient and/or guarantor(s) agree to pay reasonable attorney's fee and cost of collection if patient's account is placed in the hands of an attorney for handling.

PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act, or under other insurance coverage, is correct. I authorize any holder of medical or other information about me to release to S.S.A. or its intermediaries or carriers and/or the State in which I reside or it's Fiscal Agents, or the Insurance Company, or its representatives, any information needed for this or a related Medicare/Medicaid Claim, or other insurance claim. In consideration of services rendered, I transfer and assign to University Clinical Health any payment which may become due to me for medical and/or surgical services under policies applicable to me or my dependent.

_____
Patient Signature (Signature must be marked by witnessed)

_____
Guarantor Signature

UNIVERSITY CLINICAL HEALTH

Review of Systems

Please Answer **ALL** Questions

MRN
CHART NO
NAME
DOB

Patient Stamp Above

Have you experienced any of the following in the last 6 months?

Date: _____

CONSTITUTIONAL		○ All No
No	Yes	
		Good general health lately
		Recent weight change
		Fever
		Fatigue
		Headaches
		Night Sweats or Chills

ENT		○ All No
No	Yes	
		Hearing Loss
		Ringing in the Ears
		Earaches or Drainage
		Sinus Problems/ Pain
		Nose Bleeds
		Mouth Bleeds
		Mouth Sores
		Bleeding Gums
		Bad Breath or Bad Taste
		Sore Throat or Voice Change
		Swollen Glands in Neck/ Lymph nodes

CARDIOVASCULAR		○ All No
No	Yes	
		Heart Trouble
		Chest Pains
		Sudden Heart Beat Changes
		Swelling of Feet, Ankles, or Hands

RESPIRATORY		○ All No
No	Yes	
		Frequent Coughing
		Spitting Up Blood
		Shortness of Breath
		Asthma or Wheezing

GASTROINTESTINAL		○ All No
No	Yes	
		Los of Appetite
		Change in Bowel Movements
		Nausea or Vomiting
		Frequent Vomiting
		Frequent Diarrhea
		Painful Bowel Movements or Constipation
		Blood in Stool
		Stomach Pain
		Constipation
		Heartburn

GENITOURINARY		○ All No
No	Yes	
		Frequent Urination
		Burning or Painful Urination
		Blood in Urine /Dark Urine
		Change of Force of Strain when Urinating
		Incontinence or Dribbling
		Kidney Stones
		Male- Testicle Pain
		Female- Pain with Periods
		Female- Irregular Periods
		Female- Vaginal Discharge
		Female- # pregnancies
		Female- # miscarriages
		Is it possible that you are pregnant?
Female- Date of Last Pap Smear		
Female- Findings of last Pap Smear		
○ Normal	○ Abnormal	

MUSCULOSKELETAL		○ All No
No	Yes	
		Joint Pain
		Joint Stiffness or Swelling
		Weakness of Muscles or Joints
		Muscle Pain or Cramps
		Back Pain
		Cold Extremities
		Difficulty in Walking
		Arthritis

SKIN		○ All No
No	Yes	
		Rash or Itching
		Change in Skin Color
		Change in Hair or Nails
		Varicose Veins
		Breast Pain
		Breast Lump
		Breast Discharge
		Easy Bruising or Bleeding

NEUROLOGICAL		○ All No
No	Yes	
		Frequent or Reoccurring Headaches
		Light headed or Dizzy
		Convulsions or Seizures
		Numbness or Tingling Sensations
		Tremors
		Paralysis
		Stroke

PSYCHIATRIC		○ All No
No	Yes	
		Memory Loss or Confusion
		Nervousness/ Anxiety
		Depression
		Suicidal Thoughts
		Sleep Problems

METABOLIC/ENDOCRINE		○ All No
No	Yes	
		Glandular or Hormone Problem
		Thyroid Disease
		Excessive Thirst or Urination
		Heat or Cold Intolerance
		Dry Skin
		Change in Hat or Glove size

OCULAR		○ All No
No	Yes	
		Decreased Night Vision
		Dry Eyes
		Light Sensitivity
		Blurred Vision
		Burning Eyes

Please list your 3 chief complaints for today's visit:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature:

_____

Provider Signature:

_____

Past Medical History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Anxiety			Coronary Artery Disease			Multiple Sclerosis
		Arthritis			Depression			Osteoporosis
		Asthma			Diabetes			Phlebitis
		Atrial Fibrillation			Eczema			Renal Disease
		Blood Clots			Elevated Lipids			Seizure Disorder
		Cancer:			Gastrointestinal Disease			Skin Cancer
		Cardiovascular disease			Glaucoma			Thyroid Disease
		Congestive Heart Failure			Hepatitis/Liver Disease			Tuberculosis
		COPD			Hypertension			HIV
					Mental Disorder			Other:

Past Surgical History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Blood Transfusion			Hysterectomy			Electronic Implanted
		CABG			Knee Replacement			Bone/Brain Stimulators
		Cardiac Pacemaker			Liver Biopsy			Other:
		Hip Replacement			Organ Transplant			

Family History: (Check all that apply)

No	Yes		No	Yes		No	Yes	
		Abnormal Moles			Depression			Psoriasis
		Acne			Diabetes			Renal Disease
		Allergies			Eczema			Rosacea
		Arthritis			Elevated Lipids			Seizure Disorder
		Asthma			Genetic Disease			Stroke
		Basal Cell Carcinoma			Hypertension			Thyroid Disorder
		Blood Disorder			Inflammatory Bowel Disease			Melanoma
		Cancer:			Keloids			Other:
		COPD			Liver Disease			
		Coronary Artery Disease						

Alcohol Use:
Never
Current
Former
Amount used _____
Date Started _____
Date Stopped _____

Tobacco Use:
Never
Current
Former
Amount used _____
Date Started _____
Date Stopped _____

Drug/Other Allergies

Pediatric Patients Only:

With whom does patient live? _____

Who has guardianship of patient? _____

Does anyone smoke in the household? Yes No

FOR OFFICE USE ONLY

Ht:_____in. Wt:_____lbs. Temp:_____F BP:_____/_____ HR:_____bpm R:_____bpm

New Patient: ☐ **Yes** ☐ **No** ☐ **M** ☐ **F** ☐ **Full Exam** ☐ **Focused Exam** ☐ **Gown**

>18yo ☐ **Yes** ☐ **No** Parent or Guardian Present or consent ☐ **Yes** ☐ **No**

Resident Physician Consent ☐ **Yes** ☐ **No**

UNIVERSITY CLINICAL HEALTH

Medicine List

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____

Name of Medicine	Dose (How many do you take?)	Frequency (How often do you take this?)	Why do you take this medicine?	Start Date (When did you start taking this medicine?)	Do you have any problems with this medicine? (Yes/No)	Prescribing Doctor

MRN

Name

DOB

Patient stamp or label above

UNIVERSITY CLINICAL HEALTH

Consent and Agreement

Part I. Medical Treatment Consent:

I (the undersigned, and/or the parent or legal guardian) consent to the administration of reasonable and necessary services in connection with treatment of the above-mentioned patient at University Clinical Health (UCH). This consent includes, but is not limited to, laboratory procedures, medication administration, infusions, procedures, and/or services rendered to a patient by members of the medical staff, their representatives, and/or associates and employees under the instruction of the physician. I acknowledge that no guarantees have been made to me regarding to the results of treatments or examination in the clinic.

Part II. Release of Information, Assignment of Insurance Benefits, and Financial Agreement:

Release of Information: I hereby authorize UCH and any physician who has rendered services to release any and all information pertaining to my (or the patient's) treatment to enable the collection of benefits for the services rendered. The authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered, whether such payment is in exchange for services rendered by UCH or by the physicians. Release of Information is also authorized to any providers for follow-up medical care. A copy of UCH's *Request for Restrictions Form* must be submitted in writing to terminate this agreement.

Assignment of Benefits: I hereby authorize and assign payment directly to UCH for benefits, including secondary benefits, due to me for medical services. I understand that I am financially responsible for charges not covered by any insurance or medical benefit payor. I further acknowledge that any benefits, when received by and paid to UCH will be credited to my account in accordance with this assignment.

Financial Agreement: I understand and agree that I am financially responsible to UCH, and/or physician for any charges not covered by the authorization below or charges not covered by insurance.

I agree that in order to collect any amounts I may owe for services provided by UCH, UCH or its designee may contact me via telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in cellular charges. We may also contact you by sending text messages or e-mails, using any e-mail address you provided to us. Methods to contact may include using pre-recorded/artificial voice messages and or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that UCH and/or its designee for collecting any amounts I may owe UCH may contact me as described above.

In addition, with respect to future treatments at UCH, this document is ongoing in nature and will remain in effect until revoked by me in writing.

I hereby give permission to receive services and treatment by my physician (and/or associates) at UCH. I authorize the release of information including protected health information as needed to file for payment for services incurred. I fully understand my Financial Responsibility for services rendered at UCH.

Signature of Patient or Personal Representative*

Printed Name of Patient or Personal Representative*

Date

*Relationship to Patient (if Personal Representative)

*If Personal Representative, the patient is unable to sign because (check one): ❑ Minor ❑ Incompetent

❑ Other (explain): _____

For Office Use Only: **Date received** _____ **Received by:** _____

Check if applicable: ❑ **Patient refused to sign Consent and Agreement (explain):** _____

UNIVERSITY CLINICAL HEALTH

Office Use Only	
Name:	
DOB:	Age:
MRN:	

AGREEMENT AND CONSENT FORM

Please initial your acknowledgement and consent by each statement below:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed in 2013. **You may read it now or later.** In either case, let us know if you have any questions after reviewing it.

Print Patient Name _____ Patient Signature _____

AUTHORIZATION TO SEND APPOINTMENT REMINDERS OR OTHER ALERTS VIA TEXT MESSAGE, EMAILS or AUTOMATED VOICE MESSSAGE

I hereby authorize UCH to send appointments to me via text message, email or automated voice message system. It is my responsibility to provide the clinic with the most up to date contact information. If you have signed up for the patient portal, you will also receive appointment reminders via the portal. ☐YES ☐ NO

Phone Number, if YES _____ Email, if YES _____

FAMILY AND FRIENDS RELEASE AGREEMENT

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record. This can include any family member, spouse, or friend.

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

MEDICAL PHOTOGRAPHY

_____ I hereby authorize UCH to take and use photography of me for medical and/or educational purposes.

_____ I decline UCH to take and use photography of me for medical and/or educational purposes.

I understand that I may revoke this authorization at any time by sending my written request to: UCH Privacy Officer at 1407 Union Ave, Ste. 700 Memphis, TN 38104-3673; 901-866-8517. This revocation will be effective from the date it is received in this office and will not apply retroactively.

Signature Patient, Parent, or Guardian **Relationship to Patient** **Date**