AXIS HEALTHCARE
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New Patient Registration MRN _____

Patient Information

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Box of Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F	SSNumber	Preferred Language

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic
- ☐ Decline to Specify
- ☐ Unknown

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White or Caucasian
- ☐ Decline to Specify

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) - Required if the patient is a minor ☐ Same as patient

First Name	Last Name	MI	SSNumber	Date of Birth

Address	City	State	Zip

Please check Box of Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Relationship to Patient	Preferred Language	Employer

Emergency Contact (for minor child, this section may be used for other subscriber)

First Name	Last Name	MI	SSNumber	Date of Birth

Address	City	State	Zip

Please check Box of Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, surgeries, and medical services deemed advisable by the physicians and staff of Axis Healthcare, and Axis Healthcare affiliated medical groups to me or the above named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my Axis Healthcare affiliated medical group to release information requested by my insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me, in writing.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (Please Print) Relationship to Patient

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New Patient Registration MRN_____

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

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New Patient Registration MRN_____

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Pediatric Exam	Date
☐ Physical Exam		☐ Vaginal / C-Section (Circle One)	
☐ Breast Exam		☐ Complications before, during, or after	
☐ Cardiac Stress Test		☐ Baby discharge with mom	
☐ Pulmonary Function Test			
☐ DEXA Scan		☐ Hep B received in hospital	
☐ Echocardiogram / EKG (Circle One)			
☐ Tetanus Vaccine		☐ Hospital delivered in:	
☐ Eye Exam			
☐ FOBT (stool card for hidden blood)		☐ Who was OB-Gyn?	
☐ Foot Exam			

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

Family History – continued

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient

Occupation	Employer

Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)

Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:

Insurance (please provide the facility with a copy of the card).

Primary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's DOB
Secondary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's DOB

How did you hear about us?

☐ Billboard ☐ Facebook ☐ Insurance ☐ Outside Signage ☐ Search Engine
☐ Brochure ☐ Friend/Family ☐ Newspaper ☐ Physician ☐ Website
☐ Employer ☐ Health fair ☐ Nurse ☐ Post Card/Letter ☐ Workers Comp
☐ Event ☐ Hospital ☐ Online Ad ☐ Radio Ad ☐ Yellow Page

Other:_____

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Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

Updated 8/16/2016

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth:_____ Medical record #_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI

_____

_____

Name and Address of Individual/Facility to Disclose PHI

_____

_____

Information authorized for use or disclosure, or to be obtained:

☐History & Physical ☐Discharge Summary ☐Operative Report ☐ER Record ☐Consultation ☐Lab reports

☐Progress Notes ☐ **X**-ray reports ☐Other_____

☐Medical information between_____to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐Insurance ☐Continued Treatment ☐Legal ☐ At the request of the patient or patient's representative

☐Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or non-communicable disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

Processed by (Print Name & Dept):_____

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Section 1: Receipt Acknowledgement for the Notice of Privacy Practices

I, _____ have been made aware of the notice of Privacy Practices for Axis Healthcare. I understand that this notice states how Axis Healthcare may use and disclose my Protected Health Information ("PHI.")

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST

_____*Initial*

Section 2: Insurance Authorization and Financial Agreement

I hereby authorize Axis Healthcare to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

_____*Initial*

Section 3: Notice of Advance Directive

Do you currently have an advanced directive on file? Yes ☐ No ☐ Location:_____
Do you wish Axis Healthcare to keep record of your Advanced Directive? Yes ☐ No ☐ _____*Initial*

Section 4: Release of Records to Designated Third- Party

In addition to treating physicians and medical facilities, I authorize Axis Healthcare to release my records to the following individuals. (This should include friends, or family members responsible for picking up your records when you are unable to do so.) I understand that Axis Healthcare LLC, will not release any information to any person(s) not listed below. In addition, I understand or acknowledge that I have the right to revoke this Authorization at any time by giving Axis Healthcare LLC, a written notice at the address set forth above. My private health care information may be subject to re-disclosure by one or more of the person(s) named below and as such will no longer be protected. PLEASE PRINT

Name: _____ Phone: _____

Name: _____ Phone: _____

_____*Initial*

Section 5: Authorization to Contact

I also give Axis Healthcare LLC, permission to leave a message(s) on my answering machine if they should need to remind me of an appointment, change of appointment, etc., and are unable to reach me in any other way.

☐Yes ☐No

_____*Initial*

Patient Signature:

By signing below, I am verifying that I have read each of the five sections on this page. I understand each section and consent to and agree with the information stated in each section.

_____ _____
Patient/ Legal Representative Signature Date

_____ _____
Patient's Printed Name Relationship to Patient