Patient Registration Form

Welcome to CHI Health Care! We are happy that you have decided to partner with us for your health care needs.

Current Patient Information

Last Name:

First Name:

Middle Name:

Sex:

Date of Birth:

Social Security No.:

Address:

Zip:

City: State:

Home Phone:

Mobile Phone:

Work Phone:

Patient email:

Preferred Language:

Race:

Ethnicity:

Marital Status:

How did you hear about us?

____

Preferred Pharmacy:

Preferred Method of Contact:____________________________

Yes No

Consent to call? Yes No

Consent to download history of medications purchased through insurance? Yes No

Emergency Contact Information

Name:

Relationship:

Phone:

Employment Information

Employer Name:

Employer Phone:

Usual Occupation (current or most recent):

Billing Information (to whom statements are sent)

Relationship to patient: ___________________________

Last Name:

First Name:

Middle Initial:

Date of Birth:

Address:

Zip:

City:

State:

Social Security No.:

Phone: ( )________-- _______________

PRIMARY INSURANCE INFORMATION

Insurance Plan Name:

Policy Information	Policy Holder (if other than patient)
Patient's relationship to policy holder:	Name:
ID/Certification No.:	Address:
Policy/Group No.:	Subscriber's SSN:______-_____--______
Issue Date:	Date of Birth:
Expiration Date:	Sex (please circle): **M** or **F**
	Employer Name:

SECONDARY INSURANCE INFORMATION

Insurance Plan Name:

Policy Information	Policy Holder (if other than patient)
Patient's relationship to policy holder:	Name:
ID/Certification No.:	Address:
Policy/Group No.:	Subscriber's SSN:______-_____--______
Issue Date:	Date of Birth:
Expiration Date:	Sex (please circle): **M** or **F**
	Employer Name:

Patient Name	Date of Birth

CHI Health Care History Form

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)	Not Current
______________	______________	_ / _	☐
______________	______________	_ / _	☐
______________	______________	_ / _	☐
______________	______________	_ / _	☐

Current Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency
______________	________	________
______________	________	________
______________	________	________
______________	________	________
______________	________	________

Past Medical History

Check all diseases and conditions that apply.

- ☐ ADHD
- ☐ Bladder or Kidney Problems
- ☐ Headaches
- ☐ Muscle, Joint, or Bone Problems
- ☐ AIDS/HIV
- ☐ Blood Diseases
- ☐ Heart Disease
- ☐ Obesity
- ☐ Abuse/Domestic Violence
- ☐ Breast Cancer
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Allergies
- ☐ Cancer
- ☐ Hospitalizations
- ☐ Prostate Cancer
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Hypertension
- ☐ Reflux/GERD
- ☐ Anemia
- ☐ Diabetes
- ☐ Infertility
- ☐ Seizures/Epilepsy
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Irritable Bowel Syndrome
- ☐ Skin Problems
- ☐ Asthma
- ☐ GI Problems
- ☐ Lung Disease
- ☐ Stroke
- ☐ Thyroid Problems

Other: ____

Surgical History

Check all surgeries that apply.

- ☐ Appendectomy
- ☐ Colonoscopy
- ☐ Orthopedic Surgery
- ☐ Back Surgery
- ☐ Eye Surgery
- ☐ Prostate Surgery
- ☐ Breast Surgery
- ☐ Gastrointestinal Surgery
- ☐ Thyroid Surgery
- ☐ Caesarean Section
- ☐ GYN Surgery
- ☐ Tonsillectomy
- ☐ Cardiac Surgery
- ☐ Hernia Repair
- ☐ Vasectomy
- ☐ Cholecystectomy
- ☐ Hysterectomy
- ☐ Other

Family History

Check all diseases and conditions that apply.

- ☐ Allergy — Family member(s): ____________________
- ☐ Anemia — Family member(s): ____________________
- ☐ Arthritis — Family member(s): ____________________
- ☐ Asthma — Family member(s): ____________________
- ☐ Autoimmune disease — Family member(s): ____________________
- ☐ Cerebrovascular accident — Family member(s): ____________________
- ☐ Dementia — Family member(s): ____________________
- ☐ Depressive disorder — Family member(s): ____________________
- ☐ Diabetes mellitus — Family member(s): ____________________
- ☐ Heart disease — Family member(s): ____________________
- ☐ Hypercholesterolemia — Family member(s): ____________________
- ☐ Hypertensive disorder — Family member(s): ____________________
- ☐ Malignant neoplastic disease — Family member(s): ____________________
- ☐ Malignant tumor of breast — Family member(s): ____________________
- ☐ Malignant tumor of colon — Family member(s): ____________________
- ☐ Malignant tumor of prostate — Family member(s): ____________________
- ☐ Mental disorder — Family member(s): ____________________
- ☐ Obesity — Family member(s): ____________________

Social History

1. Advance directive (Circle one)

   Yes No

2. Education Level (Circle one)

   Less than 8th grade Some high school High school 27Year College

   47Year College Post Graduate

3. General stress level (Circle one)

   Low Medium High

4. Live alone or with others? (Circle one)

   Alone With others

5. If living with others, who? (Circle one)

   Spouse Parent(s) Mother Father Children Relatives Guardian Other

6. Financial problems? (Circle one)

   Yes No

7. Number of children?__________

8. Exercise level (Circle one)

   None Occasional Moderate Heavy

9. Diet (Circle one)

   Regular Vegetarian Vegan Gluten free

   Specific Carbohydrate Cardiac Diabetic

10. Caffeine intake (Circle one)

    None Occasional Moderate Heavy

11. Alcohol intake (Circle one)

    None Occasional Moderate Heavy

12. Age at first alcohol use? _____
13. On average, how many days per week do you drink alcohol? ______
14. On a typical drinking day, how many drinks do you have? ______
15. How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)?

16. Smoking Status (Circle one)

Neversmoker Formersmoker Current every day smoker Current some day smoker

Smoker 7 current status unknown Unknown if ever smoked

17. Tobacco-years of use? ________

18. Smoking - How much? (Circle one)

None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1 PPD 1 1/2 PPD 2PPD 3+ PPD

19. Any drug use? (Circle one)

Marijuana Opiates Methamphetamines Cocaine

Other:

20. Sexually active? (Circle one)

Yes No

21. Have you experienced what you felt was harassing, controlling, and/or abusive behavior from another person (e.g. friend, parent, partner, or authority figure)? (Circle one)

No Yes currently Yes in the past

22. Sexual orientation (Circle one)

Heterosexual Homosexual Bisexual

23. Do you identify with a religion or spiritual preference, if yes, please fill in affiliation.

____

Consent to Treatment

Release of Billing Information and Assignment of Benefits

Sometimes health insurance can be a confusing thing. We want to make the process of billing as easy as possible for you, and fair to both of us.

We ask that you agree to the following:

- I hereby assign my insurance benefits to be paid directly to CHI Health Care.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance, and I authorize and give consent for CHI Health Care to bill me directly for services performed that are not covered under the terms of my health plan.
- I authorize CHI Health Care to release any medical information required to process this claim.
- I authorize CHI Health Care to contact me by phone to remind me of my appointments.

In return, we will:

- Bill your insurance company directly for all allowable charges.
- Make every effort to help you understand what the charges will be ahead of time.

I understand and agree to the above information regarding release of billing information and assignment of benefits.

____________________________________ __________________

Signature Date

Consent to Treatment

Consent to Treatment

- I consent to treatment and care by CHI Health Care health care providers.
- I understand that my care team at CHI Health may include both allopathic (physicians, nurse practitioners, nurse care manager, etc.), behavioral health specialists (e.g. psychologists), and non-allopathic (acupuncture, reiki, etc.) providers in addition to the staff (medical assistants, front desk staff, etc.) who help provide care.
- I recognize the importance of my care team to communicate and consent to the sharing of necessary information amongst my care team in a HIPAA compliant manner that respects my privacy.

____________________________________ ________________

Signature Date

Receipt of Notice of Privacy Practices

- You can review your health information privacy rights online at http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/consumer_rights.pdf or receive a printout of this information at the office.
- While the law (HIPAA) does not require you to sign this “receipt of the notice of privacy practices” form, we at CHI request that you let us know you’ve read the notice by signing below.
- Signing does not mean that you have agreed to any special uses or disclosures of your health records.
- Refusing to sign the acknowledgement does not prevent CHI Health Care from using or disclosing health information as HIPAA allows us to do, such as for treatment, payment or health care operations.

I acknowledge I have received the HIPAA Notice of Privacy Practices. I have read and understand the information above.

____________________________________ ________________

Signature Date

Appointment Cancellation Policy

Dear Patient,

In order to give you the best possible care, time has been specifically reserved for you with our providers.

If you are unable to attend an appointment, please give us a courtesy cancellation notice of 24 hours or more to allow another patient access to timely medical care.

If you fail to show up for a scheduled appointment or do not notify the office of a cancellation at least 24 hours in advance, we reserve the right to charge your account the amount of $50.00.

Thank you for being a valued patient and for your cooperation regarding this policy.

______________________________________ _______________

Signature Date

CHI Health Care 15001 Shady Grove Rd Rockville, MD 20850 301.664.6464