PATIENT REGISTRATION FORM

First Name:	**Last Name:**	**Middle Initial:**
Mailing Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**	**Marital Status:**
Date of Birth:	**SSN:**	**Gender:**
Email:		
Race: White Black/African American Asian Native Hawaiian Other (please specify):		
Ethnicity: Hispanic/ Latino / Not Hispanic/Latino	**Preferred Language:** English Spanish Other (please specify):	
Occupation:	**Employer:**	
How did you hear about us: Newspaper / Family Member / Other		
Emergency contact information (PLEASE PROVIDE TWO):		
Name:	**Phone:**	**Relationship to patient:**
Name:	**Phone:**	**Relationship to patient:**
Person responsible for the bill (ONLY IF DIFFERENT THAN PATIENT):		
First Name:	**Last Name:**	**M.I.:**
Date of Birth:	**Phone:**	**Relationship to patient:**

Primary Medical Insurance		**Secondary Medical Insurance**	
Ins. Co. Name:		**Ins. Co. Name:**	
ID#:	**Grp#:**	**ID#:**	**Grp#:**
Policy Holder Name:		**Policy Holder Name:**	
Insurance Phone #:		**Insurance Phone #:**	
Policy Holder DOB:		**Policy holder DOB:**	
Policy Holder Relationship to Patient:		**Policy Holder Relationship to Patient:**	

PATIENT RECORD DISCLOSERS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI is made by alternative means, such as sending correspondence to the individual's work or cell phone instead of the individual's home.

Please prioritize the following modes of communication in the order in which you would like to receive calls or messages and check your preferred selected option that applies regarding detailed messages for each:

1 2 3 4	**Home Phone**		**YES – Leave a message at this number with detailed medical information.**		**DO NOT leave detailed messages, Only a callback number.**
1 2 3 4	**Cell Phone**		**YES – Leave a message at this number with detailed medical information.**		**DO NOT leave detailed messages, Only a callback number.**
1 2 3 4	**E Mail Address**		**Portal communication is verified via your email address. Through the above email address, you are given access to the encrypted patient portal which holds your medical information.**		
1 2 3 4	**Text message**		**YES – Leave a message at this number with detailed medical information.**		**DO NOT leave detailed messages, Only a callback number.**

First Name:	Last Name:	D.O.B:

AUTHORIZATION TO RECEIVE OR SEND INFORMATION

Receiving your current prescription history and progress notes from specialist and pharmacies as well as sending our information to them is necessary in better coordinating your care. Please initial below to signify you understand and

_____YES, please electronically receive and send my prescriptions to the pharmacy and to and from outside clinicians. Additionally, the outside party has permission to send the most recent information to High Mountain Health, PA.

CANCELLATION POLICY

_____I acknowledge and understand that High Mountain Health will charge a $50.00 fee for no shows or failure to cancel appointments within 24 hours of my scheduled appointment time. This includes cancellations on weekends and/or holidays.

AFTER HOURS POLICY

_____I acknowledge and understand that calls where I speak to a clinician may result in applicable fees which will be billed to my insurance company.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I hereby authorize High Mountain Health, PA to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment from my insurance company be made directly to High Mountain Health, PA (or to the party who accepts assignment). I certify that the information I have reported regarding my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: **Signature:**

If your current Primary Care office is NOT High Mountain Health and you would like your visit summaries sent to an outside office, please write the information for your primary care clinician below.

Primary Provider:_____**Phone:**_____**Fax:**_____

To maximize continuity of care High Mountain Health recommends that you choose a primary clinician within the practice, please CIRCLE ONE:

Arkadiy Shraytman, DO	Nora, Gashi, MD	Ronda White, PAc
Magdalena Kowalski, APN	Smadar Kleinstein, PAc	Jacquelyn Amodeo, APN

HEALTH MAINTENANCE

TEST OR EXAM	DATE OF LAST	LOCATION OR PERFORMING CLINICIAN
MAMMOGRAM		
CERVICAL CANCER SCREEN		
EYE EXAM		
COLONOSCOPY		

HEALTH HISTORY

First Name:	Last Name:	D.O.B:

Primary Pharmacy:
Primary Pharmacy Phone:

CURRENT MEDICATION LIST		
Name of Medication	**Dose / Directions**	**Prescriber (if not HMH)**

Do you have any of the following diagnoses			
Diagnosis	**Yes or No?**	**Date of Diagnosis**	**Specialist (if any)**
Coronary Artery Disease			
High Blood Pressure			
Diabetes (circle one): Type I Type II			
High Cholesterol			
COPD			
Asthma			
Anxiety			
Depression			

TOBACCO AND ALCOHOL USE				
Do you use any tobacco products?	YES	NO		
Are you interested in quitting tobacco?	YES	NO	I DON'T USE TOBACCO	
How many times in the past year have you had 4 or more alcoholic drinks in 1 day?	NONE	1-2	3-4	5 +
Are you interested in receiving help for any other type of substance abuse?	YES	NO	I DON'T USE OTHER SUBSTANCES	

First Name:	Last Name:	D.O.B:

Please list any Allergies	Type of Reaction

Please fill in the information for Hospital visits and Surgeries		
Date	**Hospital**	**Reason for Visit**

CIRCLE OF CARE

Specialists or Other Clinicians Currently involved in your care	Reason	Date Last Seen

FAMILY HISTORY

Family Member	Status: Deceased, Alive, Unknown	Age	Medical Condition 1	Medical Condition 2	Medical Condition 3	Medical Condition 4
Father						
Mother						
# of siblings:						
# of Children:						

ADVANCE DIRECTIVES			
Do you have a health care power of attorney, or a living will?	YES	NO	I DON'T KNOW