

## Patient Registration Form

DATE \_\_\_\_\_

DOCTOR \_\_\_\_\_

**PATIENT INFORMATION**

NAME LAST	FIRST	MI	SEX (CIRCLE) M F	DRIVER'S LICENSE #
HOME PHONE ( )	SS#	D.O.B.	Mo. / Day / Year	SPOUSE'S NAME
EMPLOYER	WORK PHONE ( )		EXT.	MARITAL STATUS S M D W STUDENT Y N
HOME ADDRESS		CITY		STATE ZIP
E-MAIL ADDRESS		BEEPER NO.( )		CELL PHONE NO.( )
EMERGENCY CONTACT: (NOT LIVING WITH YOU)		RELATIONSHIP		EMERGENCY PHONE ( ) EXT.

**RESPONSIBLE PARTY (If Not Patient)**

NAME LAST	FIRST	MI	RELATIONSHIP
SS#	D.O.B.	Mo. / Day / Year	DRIVER'S LICENSE # HOME PHONE( )
EMPLOYER	WORK PHONE ( )		EXT. CELL #( ) BEEPER #( )
HOME ADDRESS		CITY	STATE ZIP

Does your insurance offer Routine or Preventive Care Services? If yes, we need a copy of your handbook.

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**INSURANCE INFORMATION**

WE NEED A COPY OF YOUR INSURANCE CARDS AND DRIVER'S LICENSE.  
IF YOU HAVE YOUR CARDS, DO NOT COMPLETE THIS SECTION.

PRIMARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH		SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT
EMPLOYER		WORK PHONE	EXT.
SECONDARY INSURANCE	ID#	GROUP#	CO-PAY
POLICYHOLDER'S NAME LAST	FIRST	MI	
DATE OF BIRTH		SEX (CIRCLE) M F	RELATIONSHIP TO PATIENT
EMPLOYER		WORK PHONE	EXT.

**I consent to treatment necessary for the care of the above named patient. I acknowledge full financial responsibility for services rendered by Brookwood Primary Care Network, Inc. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment. I have read and fully understand the above consent for treatment and financial responsibility.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

**MEDICARE EXTENDED PATIENT SIGNATURE AUTHORIZATION**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIANS OF BROOKWOOD PRIMARY CARE NETWORK, INC. FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS OR THE BENEFITS FOR RELATED SERVICES.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PERSON OTHER THAN PATIENT

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**ROUTINE OR PREVENTIVE CARE ACKNOWLEDGEMENT**

IF YOUR INSURANCE PROVIDES ROUTINE OR PREVENTIVE CARE SERVICES, IT IS YOUR RESPONSIBILITY TO PROVIDE THIS OFFICE WITH A COPY FROM YOUR HANDBOOK IDENTIFYING THESE SERVICES TO THE PHYSICIAN BEFORE COMPLETION OF YOUR PHYSICAL.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**NOTICE OF PRIVACY PRACTICES RECEIPT**

I HAVE RECEIVED AND REVIEWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY BROOKWOOD PRIMARY CARE NETWORK, INC.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS**

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO BROOKWOOD PRIMARY CARE NETWORK, INC. I UNDERSTAND BROOKWOOD PRIMARY CARE NETWORK, INC. WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45 DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT BROOKWOOD PRIMARY CARE NETWORK, INC. MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**How did you hear about us?**

- Television
- Newspaper
- Billboard
- Radio
- Mailer

- Website
- Referring Physician –  
Physician's name?  
\_\_\_\_\_
- Other:  
\_\_\_\_\_

## PATIENT HISTORY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Main Complaint: \_\_\_\_\_

Allergies: List any medications to which you are allergic and how you are affected:

\_\_\_\_\_

\_\_\_\_\_

Medications: List all medications including vitamins and over-the-counter drugs you are now taking and the dosage if known:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING IN THE LAST SEVERAL MONTHS?  
(CIRCLE YES OR NO – PLEASE ANSWER ALL QUESTIONS)

**HEENT:**

- |  |   |
|--|---|
| <p>1. Headache or any pain in the head?      Yes   No<br/>How frequent? _____</p> <p>2. History of migraine headaches?      Yes   No<br/>How frequent? _____</p> <p>3. Blackouts or fainting?      Yes   No<br/>Actually passed out?</p> <p>4. Dizziness or light-headedness?      Yes   No</p> <p>5. Allergies or sinus problems?      Yes   No</p> <p>6. History of sinus irrigation due to infection?      Yes   No</p> <p>7. Nose bleeds?      Yes   No</p> <p>8. Change or decrease in hearing?      Yes   No</p> <p>9. Ringing or roaring in ears?      Yes   No</p> | <p>10. Eye disease or problems?      Yes   No<br/>Type? _____</p> <p>11. Double vision or ever see two objects at once?      Yes   No</p> <p>12. Blind spots or dark spots in field of vision?      Yes   No</p> <p>13. Do you wear glasses?      Yes   No<br/>Do you wear contacts?      Yes   No</p> <p>14. Mouth soreness or dryness?      Yes   No</p> <p>15. Difficulty swallowing or dryness?      Yes   No</p> <p>16. Throat soreness?      Yes   No<br/>Throat hoarseness?      Yes   No</p> <p>17. Any thyroid problems?      Yes   No<br/>Low or High (Please circle)</p> |
|--|---|

**CV:**

- |  |   |
|--|---|
| <p>1. Shortness of breath with activity?      Yes   No</p> <p>2. How far can you walk, regular pace, without getting short of breath? _____ blocks, or less distance _____</p> <p>3. Get short of breath when first lying down at night?      Yes   No</p> <p>4. Wake up short of breath during night after going to sleep?      Yes   No</p> <p>5. Wheezing or history of asthma?      Yes   No</p> | <p>6. History of pneumonia?      Yes   No</p> <p>7. Chest pain with breathing or coughing?      Yes   No</p> <p>8. Any chest pain - - sharp, dull, aching, shooting, knife-like? (Please circle one)      Yes   No</p> <p>9. Any chest pain – burning pressure or tightness?      Yes   No</p> <p>10. Heart skipping or fluttering?      Yes   No</p> <p>11. History of high blood pressure?      Yes   No<br/>Ever been treated?      Yes   No</p> |
|--|---|

**GI:**

- |   |     |    |  |     |    |
|---|-----|----|--|-----|----|
| 1. Heartburn?<br>What do you take? _____  | Yes | No | 7. Constipation or hemorrhoids?  | Yes | No |
| 2. History of ulcers or stomach bleeding?   | Yes | No | 8. Abdominal cramps or any<br>Abdominal pain?<br>Upper Lower (Please circle) | Yes | No |
| 3. Indigestion?<br>What do you take? _____  | Yes | No | 9. Abdominal pain with bowel<br>movement?                                    | Yes | No |
| 4. Type of food that bothers you or<br>you avoid?<br>_____  | Yes | No | 10. Do you use any type of laxative?<br>Type _____<br>How frequent? _____    | Yes | No |
| 5. Nausea or vomiting?  | Yes | No | 11. Weight gain or loss? (Circle which)<br>How much? _____                   | Yes | No |
| 6. Change in bowel habits, stool<br>color, frequency, or any blood or<br>diarrhea? (Circle which) | Yes | No | 12. History of gallstones or gallbladder<br>problems?                        | Yes | No |

**GU:**

- |   |     |    |   |     |    |
|---|-----|----|---|-----|----|
| 1. Burning or pain with urination?  | Yes | No | 4. History of prostate disease or<br>trouble?     | Yes | No |
| 2. Urine with blood, odor, darkening<br>like tea or coke? If yes, please<br>circle.                   | Yes | No | 5. Lose urine with coughing or<br>sneezing?       | Yes | No |
| 3. Trouble with urine stream, starting<br>stream, dribbling, cutting off too<br>soon? (Please circle) | Yes | No | 6. How many times do you get up to void?<br>_____ |     |    |

**GYN: (Women Only)**

- |  |     |    |   |     |    |
|--|-----|----|---|-----|----|
| 1. Are periods regular?<br>Number of days bleeding _____     | Yes | No | 4. Date of last Pap smear _____<br>Date of last mammogram _____ |     |    |
| 2. Do you have clots with periods?<br>Cramps with period?    | Yes | No | 5. Do you have PMS symptoms?<br>Type _____                      | Yes | No |
| 3. Do you spot between periods?<br>Date of last period _____ | Yes | No | 6. Do you perform self-breast exams?                            | Yes | No |

**ENDO:**

- |   |     |    |   |     |    |
|---|-----|----|---|-----|----|
| 1. Do you have a history of or have you<br>been treated for abnormal blood<br>sugar or diabetes?<br>If yes, how and when _____<br>_____ | Yes | No | 3. Are you on a diet?<br>Type _____                                 | Yes | No |
| 2. History of hormone or gland problems?  | Yes | No | 4. Do you exercise?<br>Type _____<br>How frequently? _____ Day/Week | Yes | No |

**MS:**

- |  |     |    |  |     |    |
|--|-----|----|--|-----|----|
| 1. Any back, neck, or spine pain?            | Yes | No | 6. Muscle cramps at night?                         | Yes | No |
| 2. Any joint aches or pains?<br>Where? _____ | Yes | No | 7. Calf or leg cramps or pain when<br>you walk?    | Yes | No |
| 3. Swelling of any joints?<br>Where? _____   | Yes | No | 8. Skin rash, new skin growths or<br>skin disease? | Yes | No |
| 4. History of arthritis?<br>Type _____       | Yes | No | 9. Change in color of skin spots<br>or moles?      | Yes | No |
| 5. Type of arthritis treatment<br>_____      |     |    |  |     |    |

**CNS:**

- |  |     |    |  |     |    |
|--|-----|----|--|-----|----|
| 1. Problems falling asleep or staying asleep?                                | Yes | No | 8. Any fears or special fear?<br>Type _____  | Yes | No |
| 2. Change in appetite?<br>If yes, too much or too little?<br>(Please circle) | Yes | No | 9. Any changes in sex drive?   | Yes | No |
| 3. Nervous problems?   | Yes | No | 10. Overall energy level up ____ down ____<br>For how long? _____                            |     |    |
| 4. Been feeling down or depressed?   | Yes | No | 11. Last time you felt good _____  |     |    |
| 5. Anxious or nervous?   | Yes | No | 12. Are you looking forward to something<br>in the future?                                   | Yes | No |
| 6. Ever had panic episodes or<br>panic attacks?                              | Yes | No | 13. Is there anything you would like to have<br>discussed or tested by your doctor?<br>_____ |     |    |
| 7. Worried? Any particular worries<br>or special worries?                    | Yes | No | 14. Do you wear seat belts regularly?  | Yes | No |

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List any inhalants or insect stings to which you are allergic: \_\_\_\_\_

Surgery: List any previous surgery and the dates \_\_\_\_\_

Have you received blood transfusions? Please circle Yes or No

Illnesses: List any previous and current medical illnesses \_\_\_\_\_

SMOKING Please circle Yes or No If yes, how many packs per day? \_\_\_\_\_ for how many years? \_\_\_\_\_

Smoked previously? Please circle Yes or No How much? \_\_\_\_\_ for how long? \_\_\_\_\_

**FAMILY HISTORY:**

Father: Living? \_\_\_\_\_ Deceased? \_\_\_\_\_  
Age if living \_\_\_\_\_ Age at death if deceased \_\_\_\_\_ Cause of death \_\_\_\_\_

Mother: Living? \_\_\_\_\_ Deceased? \_\_\_\_\_  
Age if living \_\_\_\_\_ Age at death if deceased \_\_\_\_\_ Cause of death \_\_\_\_\_

Brothers: Living? \_\_\_\_\_ Deceased? \_\_\_\_\_  
Age if living \_\_\_\_\_ Age at death if deceased \_\_\_\_\_ Cause of death \_\_\_\_\_

Sisters: Living? \_\_\_\_\_ Deceased? \_\_\_\_\_  
Age if living \_\_\_\_\_ Age at death if deceased \_\_\_\_\_ Cause of death \_\_\_\_\_

Does anyone in your family have: (State whom)

Heart trouble? \_\_\_\_\_

Tuberculosis? \_\_\_\_\_

Diabetes? \_\_\_\_\_

Strokes? \_\_\_\_\_

Inherited diseases? \_\_\_\_\_

Cancer? \_\_\_\_\_

**PERSONAL HISTORY:**

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Time with present employer: \_\_\_\_\_ Do you primarily sit on your job: \_\_\_\_\_

Spouse's age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Since your last check-up, have there been any births \_\_\_\_\_ deaths \_\_\_\_\_ big events \_\_\_\_\_?

## Notice of Privacy Practices

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will :

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TOP, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will:
  - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff will respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release, or law otherwise authorizes the release.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
  - Permit patients access to their medical records when their written requests are approved by our practice. If we deny such requests, we will inform the patients that they may request a review of our denial. In such cases, we will have an onsite healthcare professional review the patients' appeals.

- Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TOP for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.



**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for BROOKWOOD PRIMARY CARE NETWORK, INC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (BROOKWOOD PRIMARY CARE NETWORK, INC.'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. BROOKWOOD PRIMARY CARE NETWORK, INC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Peri Cabral, Privacy Officer at Brookwood Primary Care Network, Inc. – 2010 Brookwood Medical Center Dr., Homewood, AL 35209.

With this consent, BROOKWOOD PRIMARY CARE NETWORK, INC. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, BROOKWOOD PRIMARY CARE NETWORK, INC. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that BROOKWOOD PRIMARY CARE NETWORK, INC. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to BROOKWOOD PRIMARY CARE NETWORK, INC.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BROOKWOOD PRIMARY CARE NETWORK, INC. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

**CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO  
SPECIFIED INDIVIDUALS**

Brookwood Primary Care Network, Inc. is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPAA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Examples include: spouse, parent, child, brother/sister, friend, etc.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact/Relationship to patient:

Telephone Number:

1 \_\_\_\_\_

\_\_\_\_\_

2 \_\_\_\_\_

\_\_\_\_\_

3 \_\_\_\_\_

\_\_\_\_\_

( ) Home answering machine message only

( ) Voicemail message only

( ) Cell/Pager # \_\_\_\_\_