PATIENT REGISTRATION

Patient Information

Name: _____
First *Middle* *Last*

Address: _____

Social Security Number: _____Home phone: (____)_____ Cell Phone: (____)_____

Date of Birth: _____ Marital Status: _____ Gender: ◯ M ◯ F

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Black ◯ White ◯ Native Hawaiian ◯ Other Pacific Islander

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Do you have medical insurance? ◯ Yes ◯ No

If you do not have insurance, would you like to get information about our reduced fee program? ◯ Yes ◯ No

Are you a US veteran? ◯ Yes ◯ No Are you homeless? ◯ Yes ◯ No

Parent's Information (Complete this section for a patient less than 18 years old)

Mother's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Father's Name: _____ Date of Birth:_____/_____/_____
First *Middle* *Last*

Is there a Legal Child Custody Agreement? ◯ Yes ◯ No

(If yes, are there any legal restrictions that would prevent the non-custodial parent from consenting to medical/dental treatment for the child or from obtaining information about the child's medical/dental treatment?) ◯ Yes ◯ No

*****Please provide proof of parental custody orders or other legal agreements*****

Emergency Contact Person

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

_____/_____
Address *Phone*

Person Responsible for Payment (Complete this section for a patient less than 18 years old)

Name:_____/_____
First *Middle* *Last* *Relationship to patient*

Social Security Number: _____ Date of Birth: _____

Address: _____

Home phone: _____ Cell phone: _____

I agree that the above information is correct and accurate to the best of my knowledge. I also understand that any charge(s) not covered by my insurance(s) will be my responsibility.

Signature: _____ Date: _____

For Office Use Chart #: Insurance scanned: yes/no Date: Initials:

1/2/19 ksw

PERMISSION TO SHARE PROTECTED
HEALTH INFORMATION

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____Telephone:_____

Keystone Health shares one electronic record. Any person(s) you authorize will have access to your financial/medical/dental and behavioral health information.

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Keystone Health uses a reminder system and/or patient portal to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone :_____(you will receive a text message)

E-mail:_____ (you will receive an email)

By signing, I give permission to Keystone Health to share my protected health information to the individuals listed. This Permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

(Patient's 14 years and older must sign if consenting for treatment on own behalf)

_____

Staff Initials

7/30/18 ksw

Keystone Internal Medicine
Adult Health History Form

Medical History: Please **Circle** any diseases you have or have had in the past

Allergies	Cardiac arrhythmia	Heart valve disorder
Anemia	COPD	Hepatitis/ liver disease
Angina/chest pain	Coronary artery disease	Hypertension/blood pressure
Anxiety	Depression	Irritable bowel disease
Arthritis	Diabetes/sugar	Myocardial infarction/heart attack
Asthma	Elevated lipids/cholesterol	Osteoporosis
Atrial fib/abnormal heart rhythm	Gallbladder disease	Renal disease/kidney
Benign prostatic hypertrophy	GERD/acid reflux	Seizure disorder
Blood clots	Headache, migraine	Stroke
Cancer	Heart disease	Thyroid disease

Other:

_____

FAMILY HISTORY: Please **Circle** any diseases your parents, grandparents, brother, sister, aunts or uncles have /had. Please indicate which relative has/had it.

ADD/ADHD	Depression	Mental Illness
Alcoholism	Developmental delay	Migraines
Allergies	Diabetes	Obesity
Alzheimer's disease	Eczema	Osteoporosis
Arthritis	Elevated Lipids	Peripheral vascular disease
Asthma	Genetic Deficiency	Renal Disease
Blood disorder	Hearing Deficiency	Seizure Disorder
Cancer	Hypertension	Stroke
Cardiovascular disease/Heart attack	Irritable bowel disease	Thyroid disorder
Coronary artery disease	learning disability	

Other:

_____

Surgical History: Please **Circle** any surgeries you have had

Angioplasty	CABG	Colectomy	Knee replacement
Appendectomy	Cardiac pacemaker	Colostomy	LASIK
Arthroscopy	Carpal tunnel release	Gastric bypass	ORIF
Back surgery	cataract extraction	hernia repair	Thyroidectomy
Blood transfusion	cholecystectomy	Hip replacement	Tonsillectomy

Other:

_____

Medications: Prescription and non-prescription medicines (may attach med list).

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies or reactions to medications: Indicate the specific reaction you had

_____ _____ _____

_____ _____ _____

Patient Signature: _____ Date:_____

Providers Initials: _____ Date: _____

As a Community Health Center, our mission is to take care of people no matter what their race, ethnicity or income. This survey will help us know if we are helping all kinds of families within our community. Please fill in the information below to best tell us about you and your family.

Race- relates to a persons appearance such as skin color:
□ **White/Caucasian** □ **Black/African American** □ **Asian** □ **American Indian**
□ **Native Hawaiian** □ **Other Pacific Islander** □ **Multi-racial**

Ethnicity- relates to nationality and culture:
□ **Latino/Hispanic** □ **Non Latino**

Do you live in public housing:
□ **Yes** □ **No**

Family Size	Annual Family Income		
1	☐ $12,140 and below	☐ $18,210 and below	☐ $24,280 and below
	☐ $24,281 and above		
2	☐ $16,460 and below	☐ $24,690 and below	☐ $32,920 and below
	☐ $32,921 and above		
3	☐ $20,780 and below	☐ $31,170 and below	☐ $41,560 and below
	☐ $41,561 and above		
4	☐ $25,100 and below	☐ $37,650 and below	☐ $50,200 and below
	☐ $50,201 and above		
5	☐ $29,420 and below	☐ $44,130 and below	☐ $58,840 and below
	☐ $58,841 and above		
6	☐ $33,740 and below	☐ $50,610 and below	☐ $67,480 and below
	☐ $67,481 and above		
7	☐ $38,060 and below	☐ $57,090 and below	☐ $76,120 and below
	☐ $76,121 and above		
8	☐ $42,380 and below	☐ $63,570 and below	☐ $84,760 and below
	☐ $84,761 and above		
9	☐ $46,700 and below	☐ $70,050 and below	☐ $93,400 and below
	☐ $93,401 and above		
10	☐ $51,020 and below	☐ $76,530 and below	☐ $102,040 and below
	☐ $102,041 and above		

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