PATIENT REGISTRATION

Please note (*) is optional information

Patient name: Last _____First _____ MI_____ DOB: _____

Social Security Number: _____-_____-_____Sex: M / F Other_____ Circle one: Married / Single / Divorced / Domestic Partner / Living Together

Address_____
(Street) (City/State/Zip)

Primary Phone: (_____) _____-_____ *Secondary Phone: (_____) _____-_____

*Email Address: _____

***Email Opt Out:** Please do NOT use my email address for communications involving:
☐Appointment Reminders ☐Medical Test Results ☐Clinic Tips & Programs

***How did you hear about our Practice? _____**

Your language preference: ☐English ☐Spanish ☐Russian ☐Vietnamese ☐other: _____

*Ethnicity: _____ * Race: _____ (Optional, CMS request)

Person responsible for bill or parent (*COMPLETE ONLY IF DIFFERENT FROM PATIENT*)

GUARANTOR NAME: _____ DOB:_____/____/_____ SSN: _____-____-_____

Relationship to Patient: ☐Spouse ☐Parent Other:_____ Phone: (_____)_____-_____

WHO TO CALL FOR AN EMERGENCY:

Name: _____ Primary Phone: (____)_____-_____ Relationship:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder Social Security Number: _____-_____-_____
Policy Holder Date of Birth: _____/ _____/ _____ Sex: M / F

SECOND INSURANCE:

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder Social Security Number: _____-_____-_____
Policy Holder Date of Birth: _____/ _____/ _____ Sex: M / F

*IS YOUR VISIT DUE TO A **JOB RELATED INJURY**, THIRD PARTY INJURY OR **AUTO ACCIDENT**? **Y_____ N _____***

CONSENT FOR SERVICES AND/OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

I hereby consent to medical evaluation, testing and/or treatment provided to me by the staff of Rose Urgent Care and Family Practice. I also understand that Rose Urgent Care and Family Practice may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. Use of my email address for communication is permitted unless marked "NO" in the section above. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the practitioner and agree to pay any remaining balance once my Insurance Plan has processed my claim.

_____ _____
Signature of patient or parent/guardian if minor *Date*

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New Patient Health History

Please complete this form so we can get to know you better.

Name	**Date of Birth**
Primary Phone / Secondary Phone	**Today's Date**
Marital Status: □ **Single** □ **Married** □ **Separated** □ **Divorced** □ **Domestic Partner** □ **Living Together**	**Date of Last Physical Exam**
Race/Ethnic Background	**Occupation:**
Highest Education: : □ **Less than high school, highest grade completed____** □ **High School** □ **2 Year Degree** □ **4 Year Degree** □ **Post graduate**	**Sexual Orientation:** □ **Heterosexual** □ **Homosexual** □ **Bisexual**
MAIN REASON WE ARE SEEING YOU TODAY:	**PREFERRED PHARMACY:**

ALLERGIES (Drug or Food)	**YOUR MEDICATIONS NAME AND DOSAGE:** **(regularly used: prescriptions, herbs, natural products, over the counter)**

Review of Systems (Circle all symptoms that you currently have or have had in the past 4 weeks)

Constitutional	**Eyes**	Restless legs Syndrome	Coughing up blood
Fever	Dry eyes	Tremor	Sleep apnea
Night sweats	Vision changes	**Cardiovascular**	Athma
Weight gain/loss	Eye irritation	Arm pain with exertion	**Gastrointestinal**
Exercise Intolerance	Blurred/Double vision	Shortness of breath when walking	Vomiting Vomiting blood
Psychiatric	Blind spots or loss of vision	Chest pain	Abdominal pain
Depression	**Ears**	Rapid heartbeat	Change in appetite
Sleep disturbances	Earache	Heart murmur	Diarrhea
Feeling unsafe in a relationship	Ear discharge Difficulty/Loss of hearing	Shortness of breath when laying down	GERD Gas or bloating
Alcohol abuse	Ringing in ears	Chest pain with exertion	Black or tarry stools
Anxiety	**Nose**	Irregular hearbeat	Bowel habit changes
Hallucinations Drug abuse	Nosebleeds	Light-headedness on standing Fainting or near-fainting	Excessive thirst Excessive hunger
Suicidal thoughts	Nose problems	Varicose veins	Constipation
Nervousness	Sinus problems	Swelling of ankles	Indigestion/heartburn/reflux
Forgetfulness	**Mouth/Throat**	Poor circulation	Nausea
Endocrine	Sore throat	High/low blood pressure	Hemorrhoids
Chills	Bleeding gums	**Musculoskeletal**	Rectal bleeding
Fatigue	Snoring	Muscle aches	**Skin**
Increased thirst	Dry mouth	Muscle weakness	Change in or abnormal moles
Hair loss	Mouth ulcers	Joint pain	Yellowing of skin (jaundice)
Increased hair growth	Oral abnormalities	Back pain	Rash
Cold intolerance	Teeth problem	Swelling in arms or legs	Cuts (laceration)
Hematologic/Lymphatic	Mouth breathing	Neck pain	Nail problems
Swollen glands	Hoarseness	Shoulder pain	Other skin concerns
Bruising	Persistent cough	Arm pain	Bruise easily
Excessive bleeding	Difficulty swallowing	Leg pain	Itching
Allergic/Immunologic	**Neurologic**	Hip pain	Growths/lesions
Runny nose	Loss of consciousness	Foot pain	**Genitourinary**
Sinus pressure	Weakness	Hand pain	Lack of bladder control
Itching	Numbness	**Respiratory**	Difficulty urinating
Frequent sneezing	Seizures	Sputum (Phlegm)	Blood in urine
Hives	Dizziness	Frequent cougn	Increased urinary frequency
Seasonal allergies	Frequent/severe headache	Wheezing	Painful urination
Congestion	Migraines	Shortness of breath	Incomplete emptying

Past Surgical History

Type of Surgery	Month/Year	Name of Hospital or Doctor

Family History □ Adopted □ Unknown

(List blood relatives: Maternal/Paternal grandparents, aunts/uncles, parents, siblings, children)

Heart disease:	Depression:
Heart attack (myocardial infarction)	Colon disease:
Hypertension/high blood pressure	Fibromyalgia:
Stroke:	Diabetes:
Asthma:	Cancer – what type?:
Anxiety:	Blood clot or easy bleeding:

Other problems, known conditions or confidential information that you feel the provider should know:

Social History

Exercise: □ None □ Occasionally □ Moderately □ Heavy

Diet: Regular Vegetarian Vegan Gluten-Free Specific Carbohydrate Cardiac Diabetic

Stress level: □ Low □ Medium □ High

Smoking Status: □ Never □ Former □ Current every day □ Current some day Has smoked since age: ___
Packs Per Day|Week(circle):_____ Would you like help to quit smoking? □ Yes □ No

Alcohol □ None □ Occasional □ Moderate (2 drinks per day) □ Heavy (more than 2 drinks per day)

Caffeine □ None □ Occasional □ Moderate (8 oz per day) □ Heavy (>24 oz of caffeinated beverages per day

Chewing tobacco □ None □ 1/day □ 2-4/day □ 5+/day

Recreational drugs □ Yes □ No If yes, what drug, and when last used:

Guns present in home? □ Yes □ No	Advanced Directive or Living Will ? □ Yes □ No
Seat belt used routinely? □ Yes □ No	Would you like assistance preparing these documents?
Sunscreen used routinely? □ Yes □ No	□ Yes □ No
Smoke alarm in home: □ Yes □ No	Do you perform monthly self breast exam? □ Yes □ No
	Legally blind in one or both eyes? □ Yes □ No
	Hard of hearing or deaf in one or both ears?□ Yes □No

Gynecological History (Females Only)

Duration of flow (days):	Were you on birth control at conception? □ Yes □ No
If menopausal, age at menopause:	Date of last Colonoscopy:
Last menstrual period:	Date of Last Mammogram:
Frequency of cycle (days between menses):	Date of last Pap Smear:
Menses Monthly: □ Yes □ No	Have you had the HPV vaccine? □ Yes □ No
Average Flow: □ light □ moderate □ heavy	Sexual problems? □ Yes □ No
Your age at first child:	Sexually active? □ Yes □ No
Your age at first period:	Sexually transmitted infections: □ Yes □ No
Current birth control method:	Ever had an abnormal pap? □ Yes □ No
Desired birth control method:	# Pregnancies: # Living Children:
Are you taking hormone replacement therapy? □ Yes □ No	# Cesarean Sections: # Vaginal deliveries:
Date of last Bone Density test:	Have you had any post-menopausal bleeding? □ Yes □ No

Men Only

Date of last prostate exam:	Are you having any trouble passing urine? □ Yes □ No
How many times are up at night to urinate?	

Men and Women

Have you had your cholesterol checked in the last 5 years? □ Yes □ No
If so, what were the levels? □ HDL _____ □ LDL _____

If you are 50 or older, have you had a screening colonoscopy? □ Yes □ No
If yes, were there polyps? □ Yes □ No

Immunizations

Last tetanus booster:	HPV shot:
Last flu shot:	Chicken Pox/Shingles:
Last pneumonia shot:	Last Hepatitis A shot or series:
Hepatitis B series completed (series of three):	

Past Medical History (Circle conditions that you have had in the past)

Alcoholism	Diverticulitis	Kidney or bladder disorder	Tuberculosis
Allergies	Emphysema	Liver disease	Ulcer
Anemia	Epilepsy	Migraine headaches	Deep Vein Thrombosis (DVT)
Anxiety	Exposure to Asbestos	Osteoporosis/Osteopenia	Anorexia/Bulemia
Arthritis	Exposure to TB	Other serious illness	**Problems not mentioned above:**
Asthma	Fibromyalgia	Polio or post-polio syndrome	
Bleeding disorders	Glaucoma	Pulmonary embolism (blood clot in lungs)	
Blood clot	Gout	Recurrent bladder infections (UTI)	
Cancer type:_____	Heart Disease	Reflux/GERD	
COPD	Heart Murmur	Rheumatic Fever	
Cholesterol (high)	Hepatitis type:_____	Seizure disorder	
Coronary Artery Disease	Hypertension (high blood pressure)	Sexually transmitted infection type:_____	
Depression	Hyperthyroidism	Sleep apnea (or use CPAP)	
Diabetes (circle) type: 1, 2, unknown	Hypothyroidism	Stroke (Cerebral Vascular Accident)	

ROSE URGENT CARE AND FAMILY PRACTICE

Privacy Practices Acknowledgment and Consent

I understand that Rose Urgent Care and Family Practice (referred to below as "This Practice) will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan and insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all my health care; and
- Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice and my rights regarding my health information.

I understand that the Notice of Privacy Practice may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices, which will be provided at my request. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting room/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By:_____ Date:_____
(Patient)

By:_____ Date:_____
(Patient representative)
Description of Representative Authority: _____

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Rose Urgent Care and Family Practice
Cancellation, No Show and Late Arrival Policy

Your providers here at Rose Urgent Care and Family Practice want to make sure that you have access to high-quality health care when you need it. To ensure maximum access for all of our patients, please be aware of the following appointment policy:

Scheduled Appointments:

If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know. This allows us enough time to offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a missed (no show) appointment. Also, depending on your insurance plan, we will bill you a missed appointment charge of $25.00 (Twenty-five dollars).

Missed Appointments/No Show:

Missed appointments/No Show will be documented in your record with each No-Show letter mailed to you. If you've missed three appointments, you will no longer be able to schedule appointment for routine care until you have met with our Care Coordinator. You will only be allowed to schedule Same Day appointments. Upon Care Coordinator's assessment and approval, you will be able to schedule additional appointments with your provider and/or will be discharged from future care.

Late Arrivals:

We require each established patient to arrive 15 minutes prior to their appointment time to allow for registration and vital sign checks. Patient will be considered late if arriving at scheduled time and will be given one of the following directives:

1) We may reschedule the appointment
2) We may try to work you in between patients to be seen for your most urgent need. We will schedule another appointment at a later date to permit the patient to receive the full value of their time with the provider.

If you have any questions about the Cancellation, No Show and Late Arrival Policy, please feel free to speak to any member of our staff.

I understand and agree to abide by this Cancellation, No Show and Late Arrival Policy.

Patient Name _____Patient Signature_____ Date _____

_____
Parent/Guardian Name (for patients under 18 years of age)

ROSE URGENT CARE AND FAMILY PRACTICE

Narcotic prescribing policy

Thank you for choosing Rose Urgent Care and Family Practice for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain good health.

It is important that you read this prescribing policy. To be treated by a provider you must understand, agree to, and initial the provisions below.

_____The providers and staff at Rose Medical Groups are here to help patient's reach the following goal when treating pain: decreasing pain and improving function. Due to strong evidence supporting lack of benefit and increased chances of addiction and overdose, we do not prescribe opiates for long-term pain management. Evidence shows that there is similar benefit from short-term use of anti-inflammatories like Advil when compared to opiates, with no addiction, tolerance, or hyperalgesia. This is when a patient's pain increases because their body becomes more sensitive to pain, the longer they use opiates like Vicodin, Percocet and OxyContin.

_____For patients with terminal medical conditions like end stage cancer, hospice will manage pain for the patient. For patients who just had surgery, the surgeon will manage pain for the patient.

_____This clinic also follows evidence-based practice by not prescribing other addictive medications such as benzodiazepines (Xanax, Ativan, Klonopin) or hypnotic medications (Ambien) for anxiety or sleep.

_____Stimulant medication prescribing for ADHD requires a mental health evaluation and diagnosis from a licensed mental health practitioner within the last 12 months. This documentation is required prior to prescribing medications. Minimum yearly re-evaluation is also required for continued prescribing of stimulant medications.

_____Stimulant medications will not be prescribed for weight loss. We can help you reach your goals by discussing appropriate options such as diet and exercise.

_____Patients requesting refills or new prescriptions for any of these medications will be counseled and provided clinically supported alternatives. Since these are addictive drugs with potential for harm, patients who are currently on daily narcotic medications will be medically titrated down as appropriate or referred for treatment. Drug testing is required prior to prescribing and may be requested at any time during the titration period at patient's cost if not covered by insurance.

ROSE URGENT CARE AND FAMILY PRACTICE

Reasons narcotic prescriptions may be immediately discontinued

-Evidence of prescription alteration, fraud, or solid evidence presented to our clinic that the patient has been selling or sharing medication with others.

-Any type of coercion including threats of legal action or violence made against any of our staff in order to obtain medications.

-Impairment of the patient to such a degree that, in the opinion of our medical practice, the patient poses a risk to themselves or to others.

-A drug screen inconsistent with the patient's history of prescribed medication or positive for other drug use, including marijuana and alcohol.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions about this policy, please speak with your provider or practice manager.

I, _____ HAVE READ AND UNDERSTAND THE PRESCRIBING POLICY ABOVE.
Please Print Name

_____ _____
Responsible Party (Signature) Date

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Permission to Discuss and Share Healthcare Information

As a patient of Rose Urgent Care and Family Practice, there may be times when there is a need to share your health care information with others involved in your care. We cannot discuss any medical information with family or friends without your approval. Please provide the name(s) of the individual(s) who have permission to discuss and share your healthcare information. You may change, update, or revoke this form at any time.

I give permission to discuss my health care with the following individual(s):

NAME	RELATIONSHIP	TELEPHONE

☐ **I give permission to Rose Urgent Care and Family Practice to leave detailed voicemail regarding my health care at my personal phone number kept on file.**

I understand health care information may be discussed with the above noted individuals. Some of that information could include my prognosis or diagnosis, problem list, treatment plan, medications, diagnostic tests, discharge instructions and any other relevant medical information. This release does not cover information related to HIV Infection, AIDS, STD/STI, Mental Health, Drugs or Alcohol diagnosis unless you check and initial in the space below.

I do/Initial	I do not/Initial	Authorize the release of information related to:
☐____	☐____	HIV Infection, AIDS, Other Sexually Transmitted Diseases/Infections, and Sexual Health
☐____	☐____	Mental and Behavioral Health Information/Records
☐____	☐____	Drug/Alcohol Diagnosis, treatment and/or referral information

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records Release:
I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information. I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **I decline to have any of my medical information discussed with family or friends.**

Print Name of Patient: _____

Signature of Patient: _____ **Today's Date:** _____

This form is good for one year from the date listed above, or you may list an alternate permission **End Date:** _____

ROSE URGENT CARE AND FAMILY PRACTICE

PHQ-9 Depression Scale

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	○ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	○ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	○ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	○ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	○ 0	○ 1	○ 2	○ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	○ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○ 0	○ 1	○ 2	○ 3

10. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○ 0	○ 1	○ 2	○ 3

ROSE URGENT CARE AND FAMILY PRACTICE

Annual questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Rose Urgent Care And Family Practice

GAD-7 Anxiety Scale

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	○ 0	○ 1	○ 2	○ 3

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○ 0	○ 1	○ 2	○ 3