TUALITY PHYSICIANS
FAMILY PRACTICE & URGENT CARE

Tuality Physicians
900 SE Oak St Suite 202
Hillsboro, OR 97123
P: 503-640-3724
F: 503-648-8982
www.tualityphysicians.com

Peter Hoffman, MD
Brian Seitz, DC
Meghan Wallace, NP
Bill McCaffrey, NP
Joseph Resendiz, DO
Tracey Durst, NP

Patient Registration — Today's Date:

Legal Name: _____ _____ _____
Last Name First Name Middle Name

Birthdate: _____ Social Security Number: _____ Gender: Male Female
MM/DD/YYYY ###-##-####

Address: _____ _____
Mailing Address Unit Number

_____ _____ _____
City State Zipcode

Phone: _____ _____
Primary Secondary

Email: _____

Contact Preference: Primary Secondary Email Text Message **Opt in- required*
Would you like text message appointment reminders? Yes No
Would you like to sign up for the patient portal? Yes No

Demographics

Race:
American Indian/Alaskan Native Asian Black/African American Native American/Pacific Islander White Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other

Marital Status: Single Married Separated Divorced Widowed Other

Today's Appointment

Visit Reason: _____ _____
What is the reason for your visit today? *How did you hear about us?*

Primary Care Provider

Do you have a primary care provider? Yes No If yes, who is your provider? _____

Are you changing primary care providers? Yes No If yes, why? _____

Emergency Contact Information

Contact: _____ _____ _____
Name Relationship Phone

Billing Information

Are you the insurance card holder or are you covered under another person's policy? I am the card holder Other
Please provide the contact information if you chose other:

_____	_____	_____
Name	Date of Birth	Phone number
_____	_____	_____
Address	State	Zipcode

Missed Appointments

Tuality Physicians has the right to charge a $50 fee to the patient if:

1. The appointment is not canceled or rescheduled within 24 hours' notice
2. The appointment is missed (no-show) without calling to cancel

I understand that I am responsible for payment of the no show fee. I understand that this fee must be paid before my next scheduled appointment.

Signature: _____ Date: _____
Patient/Patient Representative Signature

Policies and Authorization

I have an Advance Directive on file: Yes No I would like a copy of the privacy policy: Yes No

Financial Policy: Patients are responsible for all charges for medical services. As a service to you, we will bill the insurance carriers with whom we are contracted with to a maximum of 2 carriers. Co-payments are collected at the time of service. Account balances not covered by your insurance are due within 30 days unless prior arrangements are made with the billing office. Established patients with a delinquent balance will be expected to remit payment prior to their next service. If you are unable to pay, your appointment may be rescheduled.

Workers Compensation: Claims will be filed in accordance with applicable laws. Forms must be filled out with all required information within 10 days of our initial treatment. Patients are responsible for payment for services rendered if a claim is denied, or if the 10 day filing limit expires.

Medical Records: Will be provided without charge to physicians whom you are referred by Tuality Physicians, PC and to your insurance plan for claim repayment. There is a charge for all other outgoing medical records, pursuant to ORS 192.563. All medical record requests must be prepaid prior to being processed and payment is the responsibility of the patient or guardian. Tuality Physicians, PC will process medical record requests within 30 days as prescribed by the State of Oregon.

Authorization: I, Patient/Legal Guardian, hereby consent to and authorize all treatments that may be considered necessary or advisable by the health care provider. I authorize Tuality Physicians, PC to contact the emergency contact person above and speak to them regarding my current addresses and phone number. I authorize Tuality Physicians, PC to release to my insurance company any information acquired in the course of treatment, in accordance with applicable law and with Tuality Physicians, PC patient privacy policy. (If you do not want test results to be released to your insurance company, you must pay for it out of pocket and ask your physician or nurse practitioner to "flag" the test so it will not be sent). I also authorize release of information to physicians and business associates necessary to carry out treatment, payment or healthcare operations. I agree that I am fully responsible for all expenses incurred, and hereby assign to Tuality Physicians, PC any and all insurance benefits for services rendered by Tuality Physicians, PC. I understand insurance coverage is a relationship between the insured and their insurance company. I accept financial responsibility for payment for charges incurred. Tuality Physicians, PC will attempt to file claims in a timely manner. I agree that I am responsible for payment for charges if claims are denied due to lack of information, or if payment is denied due to Tuality Physicians, PC not being provided with current insurance information. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. Responsibility for payment of treatment related to work injuries shall be governed by applicable laws. This authorization shall continue and be in full force and effect until revoked in writing.

Patient Name: _____ _____ _____
Last Name First Name Date of Birth

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

Acknowledgement of Receipt of Privacy Practices: I acknowledge and agree that I have reviewed and, if desired, received a copy of Tuality Physicians, PC's Notice of Privacy Practices posted at the front desk. *You may decline to sign this acknowledgement.*

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

CLINIC USE ONLY: Tuality Physicians, PC made good faith efforts to obtain the above referenced individual's written acknowledgement of the receipt of the Notice of Privacy Practices, but was unable to because Patient Refused Language Barrier Other Reason

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Medical Questionnaire

Legal Name: _____ _____ _____
Last Name First Name Middle Name

Medical Conditions

Do you have any medical conditions that may affect your treatment? Yes No

Diagnosis:	Onset:	Resolved:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Are you allergic to any medications? Yes No

Please list allergies and reactions: _____
_____
_____

Do you have any allergies to: Eggs Tapes Latex Iodine Solution

Medications

Please list of your medications with name, dose and frequency. _____
_____
_____

**you may also bring photos of your medication bottles*

Preferred Pharmacy and Location: _____

Procedures/Surgeries

Please list all surgeries or procedures and date completed: _____
_____
_____

Colonoscopy: _____ Bone Density (DEXA) Scan: _____

Pap Smear: _____ Normal Results? Yes No Mammogram: _____

Abdominal Aorta Ultrasound: _____ Preventative visit: _____

Family Medical History

Please note if any blood relative currently has or has had any of the following conditions:
**P/M refers to Paternal/Maternal Grandparent*

Condition:	Mother	Father	Sister	Brother	Grandmother/Father	P/M
Alcohol Abuse						/
Cancer						/
Drug Abuse						/
Mental Illness						/
Stroke						/
Thyroid Disorder						/
Other (Please Specify)						
						/

_____

If you checked yes for any of these conditions, please specify what type and what age they were diagnosed if applicable:

_____

Social History

Alcohol

Do you consume alcohol? Yes No
If yes: How Much: _____ How Often: _____ What age did you start/quit: _____

Tobacco

Do you use tobacco? Yes No
If yes: What type: _____ How much: _____ How Often: _____
When did you start: _____ When did you stop: _____

Substance Abuse **This information is confidential and will only be used for medical purposes*

Have you ever used illegal substances? Yes No
Do you still use illegal substances? Yes No
Do you use recreational marijuana? Yes No
Do you misuse prescription drugs? Yes No

Home and Environment

Marital status: Single Married Divorced Widowed Separated Partners Name: _____

Children's Name and Age: _____
Who lives with you at home? _____

Nutrition and Health

Do you have any special nutritional or dietary needs? Yes No Explain: _____

Exercise and Physical Activity

Times per week: Never 1-2 times 3-4 times 5-6 times Daily Duration: _____
Type of exercise: _____

Employment and Education

Are you employed? Yes No Are you a student? Yes No Full time Part time

What type of work do you do? _____

Who is your employer? _____

Highest Level of Education?

High School Diploma GED Some College Associates Degree Bachelors Degree Other

Sexual History * *This information is confidential and is only used for medical purposes*

Are you sexually active? Yes No

Current number of partners: _____

Contraception method: Condoms Oral Contraceptives IUD Implant Other

If other, explain: _____

What is your current gender identity? _____

What is your sexual orientation? _____

Religion

Do you have any medical preferences related to religious beliefs? Yes No Explain: _____

Would you like to share any religious or spiritual beliefs with your medical provider? Yes No

OBGYN History

Have you had any miscarriages or pregnancy terminations? Yes No Dates: _____

Menstrual History

Age at first menses: _____

Frequency of menses: _____ Days

Length of menses: _____ Days

Immunizations Do you choose to immunize? Yes No

Are you up to date on your immunizations? Yes No

Can you provide a copy of your immunizations? Yes No

Did you receive your immunizations in Oregon? Yes No

Specialists Do you see any specialists? Yes No

Please provide name of any specialists, naturopaths, or chiropractors: _____

_____