The Charleston Wellness Center

Patient Registration Form

Today's Date: _____ Primary Care Physician (PCP): _____

Patient Name: _____
First Middle Last

Home Address: _____
Street City State Zip

Primary Phone: _____ Alternate Phone: _____ Age: _____

Email: _____ Birth date: _____ Female

SSN: _____ Marital Status: Divorced

Spouse Name: _____ Parents (for minors): _____

Mailing Address (If different from physical address):

_____
Street City State Zip

Employer: _____ Work Phone: _____

Please list who we may notify in the event of an emergency: *(Please list at least one contact outside of your household.)*

Contact: _____ Relationship: _____ Telephone: _____

Contact :_____ Relationship: _____ Telephone: _____

Complete this section if patient is a minor or if the patient is not financially responsible.

Responsible Party: _____ Relation to Patient: _____

Birth date: _____ Age: _____ SSN: _____

Marital Status: Divorced Spouse Name: _____

Mailing Address (If different from patient):

_____
Street City State Zip

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

Name, Address and Phone number of primary insurance:_____

Group Number: _____ ____ Insurance ID Number: _____

Patient's relationship to insured: Other Other: _____

Secondary Insurance information (if applicable): _____

_____

No Insurance Coverage or Self-Pay _____
Please Sign

PHARMACY INFORMATION

Name, Address and Phone number of preferred Pharmacy:_____

Signature of Patient or Responsible Party

Please send copy of insurance card!

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Health History

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____

Person providing information: _____

Allergies

Do you have any drug allergies? Yes or no. If yes, please let us know what medications you are allergic to and what type of reaction do you have to the medication? _____

_____

_____

_____

Medications

Are you currently taking medications? Yes or no. If yes, please list medication(s), dosage(s), and frequency (please attach a separate list with today's date, if more space is needed).

Medication(s)	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had surgery or been hospitalized? Yes or no. If yes, please list reason and date(s).

_____

_____

_____

Medical History

Please list any conditions that you have been treated for or are currently being treated for.

_____

_____

_____

_____

Family History

	Siblings	Mother	Father	Mother's Parents	Father's Parents
Alcoholism					
Asthma, Lung Disease					
Bleeding Disorders					
Cancer					
Diabetes (specify type)					
Epilepsy, seizure disorder					
Glaucoma					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Mental Illness, depression, anxiety, ADHD, etc.					
Migraines					
Osteoporosis					
Stroke					
Thyroid Disease					
Other (specify)					

Please list any other information that you feel is pertinent to your medical care:

_____

_____

_____

_____

The Charleston Wellness Center

Assignment of Benefits and Authorization to Release Records

I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to the appropriate provider at Charleston School Based Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named providers may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

HIPPA PATIENT ACKNOWLEDGMENT AND CONSENT: I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document. By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and health care operations. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we may obtain. You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect the action we have or will take in reliance to this consent before we received your revocation and that not signing this consent or by revoking such consent in the future, we may reserve the right to refuse treatment.

☐ I authorize the providers of the Charleston School-Based Health Center (Charleston Wellness Center, Schmitz Family Clinic, Western Ark. Counseling & Guidance Center) to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in my case.

☐ I authorize the providers of the Charleston School-Based Health Center (Charleston Wellness Center, Schmitz Family Clinic, Western Arkansas Counseling & Guidance Center) to file my insurance for services provided.

☐ I have been notified of the Charleston Wellness Center's Privacy Practices for Protected Health information.

_____ _____

Responsible Party Printed Name Date

_____

Responsible Party Signature

_____ _____

Patient Name Date

☐ I wish to receive a printed copy of The Charleston Wellness Center's Privacy Practices for Protected Health Information.

☐ I have been provided with a printed copy of The Charleston Wellness Center's Privacy Practices for Protected Health Information.

SUBMIT