Date :_____ **NAME:**_____ **DOB:**_____

Reason for visit: _____

_____

Preferred Pharmacy: _____

Medical Providers you see:

Gastroenterologist:_____ Gynecologist:_____

Urologist:_____ Endocrinologist: _____

Other medical providers:_____

Do you have any medication allergies? (circle one) **YES NO**

If **yes**, please list the medication(s) and the type of reaction (s):

_____

_____

Please list all your medications with dosage and frequency:

_____ _____

_____ _____

_____ _____

_____ _____

Please place in "X" next to each vaccine you have received and the last vaccinated date if known:

__INFLUENZA _____ __ PREVNAR 13 _____ __ SHINGRIX _____

__COVID-19 _____ __PNEUMOVAX 23 _____ __ TDAP _____

GYNECOLOGICAL HISTORY

Please list date of most recent for the following:

Mammogram: _____ Colonoscopy: _____ Bone Density: _____ Last period:_____

Pap smear: _____ Have you ever had an abnormal pap smear? **YES** or **NO** _____

Current birth control:_____ Hysterectomy: _____ Number of Pregnancies: _____

Living:_____ FULL term: _____ Premature: _____ Miscarriage:_____ Abortion:_____

FAMILY HISTORY

Please list any medical history to each family member

Mother: _____

Father: _____

Brother: _____

Sister: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

OTHER: _____

SOCIAL HISTORY

Do you have an advanced directive? **YES** OR **NO**

Do you have a medical power of attorney? **YES** OR **NO**

Are you a current tobacco user? **YES** OR **NO** Are you a Former tobacco user? **YES** OR **NO**

If yes, what type of tobacco product did/ do you use? _____

What age did you start using tobacco products? _____

How many years have you used tobacco products ? _____

Do you use E-cigarettes or other smokeless tobacco products? __**CURRENT** __ **FORMER** __ **NEVER**

Do you use any illicit or recreational drugs? **YES** OR **NO** if yes what drug? _____

How often do you consume alcohol? **DAILY** **WEEKLY** **MONTHLY** **NEVER**

How many years have you consumed alcohol ? _____

In the last year how many days have you consumed more than 4 drinks in a day? _____

Level of caffeine intake: **LOW** **MEDIUM** **HIGH** What type of caffeine: _____

ACTIVITIES OF DAILY LIVING

Are you able to care for yourself? **YES** OR **NO**

Are you blind or do you have difficulty seeing? **YES** OR **NO**

Are you deaf or do you have serious difficulty hearing? **YES** OR **NO**

Do you have difficulty concentrating, remembering or making decisions? **YES** OR **NO**

Do you have difficulty walking or climbing stairs? **YES** OR **NO**

Do you have difficulty dressing or bathing? **YES** OR **NO**

Do you have difficulty doing errands alone? **YES** OR **NO**

DIET AND EXCERCISE

What type of diet are you following:

REGULAR DIABETIC VEGETERIAN GLUTEN FREE VEGAN CARDIAC CARBOHYDRATE OTHER

Exercise level : **LOW MEDIUM HIGH**

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

HOME AND ENVIRONMENT

Do you have any pets? **YES** OR **NO**

Do you have smoke and carbon monoxide detectors in your home? **YES** OR **NO**

Are you passively exposed to smoke? **YES** OR **NO**

Are there any guns present in your home? **YES** OR **NO**

Do you use sunscreen routinely? **YES** OR **NO**

Do you wear a helmet while biking? **YES** OR **NO**

Do you use your seatbelt or car seat routinely? **YES** OR **NO**

What is your relationship status? _____

Are you sexually active? _____ Do you use protection during sex? _____

What is your highest level of education?_____ Are you currently Employed? _____

What is your occupation? _____

Have you recently traveled abroad? **YES** OR **NO** WHERE? _____ WHEN? _____

SURGICAL HISTORY

Please list out all surgeries and the dates they were performed:

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History Please circle below any past medical history that applies to you.

ADHD
Allergies
Anemia/Blood Disorder
Aneurysm
Anxiety Disorder
Arthritis
Asthma
Atherosclerosis
Back and Neck Problems
Blood Clots
Bowel Problems
Breast Problems
Bronchitis
Cancer, type _____
Irregular heart rhythm
Carotid Blockage
Coronary Artery Disease
Dementia
Depression
Diabetes
Dialysis
Dizziness
Ear Problems
Eye Problems
Female Problems/Infections
Gout
Headaches
Heart Disease
Heartburn/Reflux
Hepatitis/Liver Disease
Herpes
High Cholesterol
HIV/AIDS
Hypertension
Kidney Disease
Lung Disorder
Osteoporosis
Pneumonia
Prostate Problems
Pulmonary Disease
Pulmonary Embolism
Radiation/Chemotherapy
Rheumatic Fever
Seizures
Skin Problems
Sleep Disorder
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Urinary/Bladder/Kidney Problems
Use of Blood Thinners
Vascular Disease
Mental Health Disorder
Sexually Transmitted Disease

Have you been hospitalized or seen in the ER in the past year? **YES** **NO** Why? _____

CRESTWOOD MEDICAL GROUP

Patients and Providers Working Together!

The health and well-being of our patients is a top concern of Crestwood Medical Group. Our primary goal is to provide the best possible care to every patient. The only way to meet this goal is for me, the provider, and you, the patient, to work together in a partnership.

For the patient:

- Complete a yearly Medicare Wellness exam or a yearly physical for patients over 40 years old. For patients 19 to 40 years old, we recommend a yearly physical.
- Bring your medicine bottles to your appointments to make sure we have accurate records and so that we can make sure all refills are taken care of.
- Request that your pharmacy contact our office for refills needed outside of your appointment. Refills may take up to 72 hours to process.
- Keep scheduled appointments. If you must miss your appointment, please cancel at least 24 hours ahead of time. Arrive before your appointment time to allow for updating your insurance or medical history.
- Complete lab work and imaging. It is a vital part of your health care.
- Schedule telehealth appointments by video or phone for some types of visits. Your provider will let you know if telehealth is appropriate for the visit.
- Use the patient portal to communicate with your provider and staff about routine concerns or questions. The portal is also a great way to view your lab and test results.

For the provider:

- Help you understand your health needs, conditions, treatment, and expected outcomes in terms that are clear to you.
- Learn the latest treatment methods, materials, and medicines to improve your health.
- Provide 24-hour access to healthcare to you personally or through an on-call answering service.
- Recommend a trusted specialist, if necessary, and coordinate the referral.
- Communicate your results to you promptly by phone or through the patient portal.

ADULT PATIENT REGISTRATION

Patients Name:_____
Last Name First Name Middle Name Name you go by

Address:_____ Apt:_____

City:_____ State:_____ Zip:_____ Marital Status:_____

Sex at birth: F M Gender identity (if applicable):_____ Pronouns:_____

Birth Date:_____ Age:_____ SS#:_____ Driver's Lic#:_____

Cell #:_____ Home #:_____ Work#:_____

Email Address:_____ How did you hear about us?_____

Consent to Text:____Yes____No Pharmacy Information _____

Language: ____ English ____ Spanish _____ _____Other (specify)

Race: ____ American Indian or Alaska Native ____ Asian ____ Black/African American ____ Hispanic/Latino ____White

____ Native Hawaiian/Pacific Islander ____ I decline to answer

Ethnicity: ____ Hispanic/Latino ____ Not Hispanic/Latino ____ I decline to answer

Employer:_____ Occupation:_____

Emergency Contact:

Name:_____ Relationship:_____ Ph#:_____

Guarantor: Person responsible for the bill:_____Self_____Spouse_____Parent_____Other

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt:_____

City:_____ State:_____ Zip:_____ Employer:_____

Sex:___F___M Cell #:_____ Home #:_____ Work #:_____

Insurance Information:

1-Primary Insurance Co:_____ Subscriber name:_____ DOB:_____

Patient ID:_____ Group #:_____

2-Secondary Insurance Co:_____ Subscriber name:_____ DOB:_____

Patient ID:_____ Group #:_____

Signature:_____ **Date:**_____

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.
I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.
2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**
I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.
3. **CONSENT TO RELEASE HEALTH INFORMATION:**
I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.
4. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.
5. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**
I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.
6. **CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:**
I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location.
The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Patient Label

I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

7. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for health care decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.
Please check one:
I have executed an advance directive and have supplied a copy to the Physician Clinic.
I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).
I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

8. **RESEARCH STUDIES:**
Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)*
Who can the Physician Clinic contact with questions about the Study?

9. **CONSENT TO PHOTO/VIDEO:**
I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

10. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**
I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

11. **E-MAIL:**
I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.
Email Address:

12. **COMMUNICATIONS:**
I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

13. **VIDEOTAPING/RECORDING:**
I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	If Telephone Consent, Second Witness Signature	Date/Time

Patient Label

ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.

All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*

	YES	NO
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

Patient/Family Member/Companion Signature	Date/Time ☐ AM ☐ PM
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time ☐ AM ☐ PM

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-256-429-4000 (TTY: 1-800-548-2546).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-256-429-4000 (TTY: 1-800-548-2546).

이 제공자는 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-256-429-4000 (TTY: 1-800-548-2546)번으로 전화해 주십시오.

Signature	Date/Time ☐ AM ☐ PM
Witness	Date/Time ☐ AM ☐ PM

Patient Label

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name		
Patient Signature	Date	Time

☐ Patient Refused Access to the Portal

Clinical Staff Signature (witness to refusal)	Date	Time

Patient Label