PROSPECT HEALTH

1035 Wall St Ste 206 Jeffersonville, IN 47130 P: 812-900-7850 F: 812-900-7851

Patient Registration

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

MailingAddress_____ City:State:_____ Zip:_____

PhoneNumber: Home_____ (voicemailY/N) Cell :_____ (voicemail Y/N)

Gender: M/ F Social Security#:_____ Marital Status: _____ Race:_____ Ethnicity:_____

RESPONSIBLE PARTY INFORMATION (if different from above): Relationship to patient: _____

LastName:_____ FirstName:_____ MiddleInitial:

_____ MailingAddress:_____ City:_____ State:___

_____ Zip:_____

PhoneNumber:Home_____ Cell: _____ Work: _____ Date ofBirth:_____

INSURANCE POLICYHOLDER INFORMATION

Primary

Insurance Name:_____ SubscriberID#:_____ Group#:_____

Insurance Address:_____

Insurance City/State/Zip: _____ Effective Date: _____

Subscriber Name (If different from above): _____ Date of Birth: _____

Relationship to patient: _____

Secondary

Insurance Name:_____ SubscriberID#:_____ Group#:_____

Insurance Address:_____

Insurance City/State/Zip: _____ Effective Date: _____

Subscriber Name (If different from above): _____ Date of Birth: _____

Relationship to patient: _____

*** EmergencyContact:**_____ Phone#:_____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Prospect Health and its agents to release any medical or incidental information that may be necessary for either medical care, to submit a health insurance claim, in processing applications for financial benefits, for quality assurance, or for Prospect Health review for the purpose of medical research.

ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment direct payment of medical benefits to Prospect Health for services rendered. I understand that I am financially responsible to Prospect Health for charges not covered by this assignment. In some cases, your provider fee is not covered in full by your insurance company. This balance due includes provisions set by your insurance company such as copayments, deductibles, and "usual and customary" allowance.

GUARANTEE OF PAYMENT:

In consideration of all medical services given by Prospect Health to the patient named above, I agree to pay Prospect Health all fees and charges made for services, which may include the cost of collection and/or reasonable attorney's fees. Payment is due and payable within 30 days of billing date. A late charge may be added to the account for all charges not paid within 30 days.

I hereby certify that the foregoing information is true and complete. I have read and hereby agree to be bound by the terms of these agreements as set forth. A photocopy of this form shall be valid as the original. I understand it is my responsibility to notify Prospect Health of any changes to the above information.

ELECTRONIC PRESCRIPTIONS: Our medical record program accesses your prescriptions/medication history in order for us to safely prescribe your medications. By signing this, you authorize us to do so.

I certify that the information provided is complete and accurate to the best of my knowledge.

Signature of Patient/Responsible Party:_____ **Date:**_____

Print Name of Patient or Responsible Party:_____ **Date:**_____

PROSPECT HEALTH

New Patient Medical History

Please Note: All information is confidential and will become part of your medical record

Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY.**

Patient Name:		Date of Visit:
Date of Birth:	Age:	***Home Phone:*** ***Other Phone:***
Preferred email:		Social Security Number:
Address:		***Emergency Contact (Name and Number):***
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner		Spouse/Significant Other:
Employer:		Occupation:
PRIMARY INSURANCE CARRIER:		**INSURANCE ID #:**
Does your insurance plan require referrals for specialty visits? ❑ Yes ❑ No		If YES, do you have a referral for today's visit? ❑ Yes ❑ No

Reason/s For Visit:

Medical History		
Please include all medical problems even if not relevant to this visit. If no medical problems, write none.		
Current or Past Medical Problems	**Dates**	**Reasons**

Hospitalizations/Surgeries	**Dates**	**Reason**

Allergies (Medication, Food, Cosmetics, Etc.)	**Cause/Nature of Reaction**

Medications/Supplements	Dosage/Frequency	Condition/Reason

Family and Social History			
Family History: **Mother**	Family History: **Father**	Family History: **Siblings**	Family History: **Children**
❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:	❑ Alive ❑ Deceased ❑ Unknown ❑ Heart Disease ❑ Diabetes ❑ Cancer (Type:) ❑ Other:

Do you drink **alcohol**?	Do you **smoke**?	Do you use recreational **drugs**?
❑ Never ❑ Yes. I drink ❑ wine ❑ beer ❑ liquor ❑ I have _____ drink(s) per week ❑ I used to drink but quit in _____ (year)	❑ I never smoked ❑ Yes. I smoke ❑ cigarettes ❑ cigars ❑ pipes. ❑ I currently smoke and I don't want to quit ❑ I currently smoke but I'm ready to quit. ❑ I smoke _____ pack(s) per day for _____ years ❑ I used to smoke but quit in _____(year) ❑ I use chewing or smokeless tobacco	❑ Never ❑ No, but I have used _____ ❑ Yes, I use _____

Do you eat or drink foods containing **caffeine?**	Have you taken any **aspirin, Advil, Nuprin** (NSAIDs) in the last 7 days?
❑ Yes ❑ No	❑ Yes (if so, what medication? _____) ❑ No

Do you **exercise?**	**If yes, how often and what type?**
❑ Yes ❑ No	

Date of most recent flu shot (age 6 months+):	Date of most recent pneumonia shot (age 65+):

How did you hear about us?

❑ Physician ❑ Family/Friend ❑ Internet ❑ Health Plan ❑ Advertise ❑ Referral Service ❑ Weill Cornell Connect ❑ Int'l Office

Consent to Discuss Medical and/or Billing Information with Others

Prospect Health LLC, including its providers, staff and covered representatives, are restricted from discussing any aspect of your care with friends or family members. These restrictions are in place due to State and Federal regulations, including HIPAA, and are ultimately intended to protect your privacy.

There are circumstances where you may wish for us to have open communication with one or more individuals to help support you in your medical treatment, and we will be happy to support that request with this signed consent.

Statement of Consent to Discuss:

By signing this release form, I, _____ (patient name) do hereby give permission for Prospect Health Providers and Staff to discuss issues related to my health care with the following person:

_____ _____

Name of authorized party *Relation to Patient*

I understand that this permission applies to all aspects listed:

- ☐ Billing information
- ☐ Mental health and/or substance use history
- ☐ Lab results
- ☐ Imaging results
- ☐ Office Notes
- ☐ Appointment scheduling, rescheduling and or canceling

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Expiration date for Consent: _____ or check here for no expiration: ☐ *

** Forms older than one year may require renewal as circumstances evolve*

Prospect Health LLC

1035 Wall St Suite 206, Jeffersonville, IN 47130 P: 812-900-7850 F: 812-900-7851

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I hereby authorize the disclosure of information for my health records.

Patient Name: _____ Date of Birth: _____

Address: _____

Information Requested: Circle one or all: All Records - Imaging - Labs

Purpose of Release:

____ Continuance of Care ____Transfer of Care

_____

The Information Is to Be Provided: To _____ or received from _____

Name Organization/Facility: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Patient's Signature: _____ Date: _____

Patient's Representative: _____ Date: _____

HIPAA Authorization for Release of Medical Records, this information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.