CALDERA
family medicine

Registration Form

Last Name, First, Middle	Date of Birth:	Sex at Birth: M / F
Is this your legal name: Y / N	Former Name:	Social Security #
Phone Number:	Email Address:	
Street Address:	City, State, Zip Code:	
Occupation:	Employer:	Employer Phone #
Primary Insurance Name:	Policy #	Group #
Secondary Insurance Name:	Policy #	Group #
Preferred Pharmacy:	Pharmacy Location:	
How did you hear about us?		

	RACE		ETHNICITY		PREFERRED LANGUAGE
☐	American Indian or Alaska Native	☐	Hispanic	☐	English
☐	Asian	☐	Non-Hispanic/Non-Latino	☐	Spanish
☐	Native Hawaiian, Pacific Islander	☐	Other:	☐	Other:
☐	Black or African American	SEXUAL ORIENTATION			
☐	White or Caucasian	☐	Straight or Heterosexual	☐	Choose not to disclose
☐	Other:	☐	Lesbian, Gay, or homosexual	☐	Other:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Caldera Family Medicine. I understand that I am financially responsible for any balance. I also authorize Caldera Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____/_____/_____

These forms are also available in Spanish upon request / Estos formularios también están disponibles en español si los solicita

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Health History Questionnaire

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record)

PATIENT INFORMATION	
Last Name, First, Middle:	Date of Birth:

MEDICATIONS		
Name of the Drug	Strength	Frequency Taken

LIST ANY PREVIOUS MEDICAL DIAGNOSIS

ALLERGIES	
Name of drug, food or item	Reaction

SURGERIES		
Year	Reason	Hospital

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FAMILY HEALTH HISTORY		
	Age	Significant Health History
Father		
Mother		
Grandmother (maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		

Have you ever had a blood transfusion?	□ Yes □ No

Sexual Activity History
Are you sexually active? □ Yes □ No
Do you have sex with men? Women? Both? (check all that apply) □ Men □ Women
How many partners have you had in the last 3 months? One year?
Any discomfort with intercourse? □ Yes □ No
Illness related to HIV, has become a public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to discuss this today? □ Yes □ No

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Patient Rights and Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices and information regarding Patient Rights. We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record. You may see your record by contacting our office in writing, or visiting MyChart, the patient portal. You may also ask to correct that record. We will only disclose your record to other treating providers, insurance companies for payment, to coordinate your care, or when we are compelled to by law. All other disclosures of your record require your authorization.

Please select the following settings.

Opt for MyChart (Patient Portal): ◯ Yes ◯ No
Opt to receive Text Messages: ◯ Yes ◯ No
Consent to Telehealth Visits: ◯ Yes ◯ No
Option for receiving Billing Statements: ◯ Paper ◯ Electronic
Opt for Health Information Exchange (Care Everywhere): ◯ Opt In (Default) ◯ Opt out

Please Note:

Health information exchange: This allows Caldera Family Medicine to share your information electronically with other treating physicians. This will be done by fax, telephone, or mail if you choose to Opt Out. If you have questions, please see our *Care Everywhere Information Packet*.

MyChart: By signing up for MyChart you will be able to securely view and share your medical record, communicate with your care team, receive immediate notification of prescriptions sent, new laboratory results, receive billing statements electronically, and many other benefits.

Authorization to release Personal, Medical, or Billing information to the following individual(s): I authorize the following person(s) to have access to my complete medical record and I give my permission to discuss my care in detail with the person(s) listed below:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

<u>Who to contact in case of emergency:</u>

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

Patient (or legally authorized individual) Signature_____

Patient Name Print_____

Patient DOB:_____/_____/_____ **Signature Date:** _____/_____/_____

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Caldera Family Medicine Policies

If you are new to Caldera Family Medicine, we welcome you and express our appreciation that you have chosen our office to provide your primary care needs. If you are an established patient, we thank you for continuing to allow us to provide your primary care.

Telephone Calls ____ (Initials)

Should you have a question or feel the need to speak to your provider by phone, we are available to answer phone messages during clinic hours, when we are not providing direct patient care. Depending on the circumstance, a medical assistant may be asked to return your call after discussing the matter with your provider. Considerable effort is made to respond to phone messages within 24 hours of their receipt.

Referrals to Specialty Care ____ (Initials)

If your insurance company requires you to have a referral from your PCP prior to seeing a specialist, they also require your PCP to conduct an evaluation of your medical need for specialty care. Therefore, if you believe you need to see a specialist, we ask that you make an appointment with your provider.

Prescription Refills ____ (Initials)

Please contact your pharmacy 72 hours prior to your prescription being due for a refill. This will allow enough time for the pharmacy and your provider to receive and respond to your request before you run out of your medication.

Narcotic Prescriptions ____ (Initials)

Lost, stolen, or damaged narcotic/controlled substance prescriptions **WILL NOT** be replaced. Therefore, prior arrangements need to be made to ensure pick up of prescriptions. If you are prescribed a narcotic or controlled substance, you will be required to sign and abide by the “Controlled Substance Agreement” policy.

Cancellation of Appointments/No Shows ____ (Initials)

We ask that you provide at least 24 hours advance to cancel an appointment. If you are unable to keep your appointment and are unable to provide at least a 24 hour notice due to circumstances not under your control, please let us know as soon as possible. This allows us to schedule another patient requiring care. Please be advised, we reserve the right to terminate our medical relationship with you if this occurs on more than three occasions combined. You may be billed for any scheduled visit that you fail to cancel within 24 hours of the appointment or fail to show up for such an appointment. This billed amount may range from $100 up to and including the estimated amount of the appointment.

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Authorization For Disclosure of Protected Health Information

Last Name:	**First:**	**MI:**	**Other Names:**
Patient address:			**Date of birth:**
Email address:	**Phone:**		**Legal Sex:**

Releasing records from *(Facility Name Here)*:	
Street Address:	
City:	**State:**
Phone:	**Fax:**

Releasing records to *(Individual or Facility Here)*:	
Street Address:	
City:	**State:**
Phone:	**Fax:**

Records to be Released

Please specify dates if applicable. If no dates are added, the default will be the last 2 years of records from the patient or representative signature date.

❍ **Progress Notes:**_____ ❍ **Immunizations:**_____ ❍ **Procedures/Imaging:**_____ ❍ **Labs:**_____ ❍ **Other:** _____ ❍ **All Records - <u>Include</u> Billing:** _____ ❍ **All Records - <u>Exclude</u> Billing:** _____	**Purpose for Disclosure:** ❍ **Continuity of Care** *(Health care coordination)* ❍ **School** ❍ **Patient Request** *(Personal records)* ❍ **Transfer of Care** *(Changing providers)* ❍ **Other:**_____

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. ***I understand that this information will not be disclosed unless I place my initials in the space next to the information.***

HIV/AIDS:	**Mental Health:**	**Genetic Testing:**	**Drug/Alcohol Treatment:**

Delivery Method:	❍ **MyChart** *(Personal Release)*	❍ **Fax** *(Third Party Release)*
Alternative Method: *Fees may be added if these options are selected.*	❍ **Hard Copy/Pick Up**	❍ **Mail**

⇦ ***Please see other side for Signature.*** ⇨

By signing this form, I authorize this disclosure of my protected health information.

***This Authorization is valid for one year from the date of signing unless otherwise specified. I can revoke this authorization at any time.** The cancellation will not affect any information about my care. I understand that state and federal law protect information about my care. I understand what this agreement means, and I approve of the disclosures listed. I am signing this authorization of my own free will.*

Signature (patient or representative):	
Relationship to patient:	**Date:**

Please note, if patient representative, supporting documentation must be present at time of signature.

Signature of staff witness:	
Printed staff witness name:	**Date:**

For CFM Staff Use Only	
Method of release:	
Signature of release staff:	**Complete date:**