Stillwater **Medical Center**
CLINICS

REGISTRATION

Patient Name (Last, First, Middle): _____

SSN: _____-_____-_____ Birth Date: _____/_____/_____ Sex: Female

Billing Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single

Race: Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language: _____ Religion: _____

Primary Care Physician: _____ Local pharmacy: _____

Mail order pharmacy: _____

Home phone: _____ Cell phone: _____

Email address: _____ *Patient portal and survey reasons only

Employer _____

EMERGENCY CONTACT

Name: _____ Phone: _____

GUARANTOR (if patient is a minor)

Name: _____ Relationship to patient: _____

Birth Date: ____/____/_____ Home phone: _____ Cell phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I request payment of authorized Medicare and/or commercial insurance benefits to me or on my behalf for any services furnished me by or in SMC. I authorize any holder of medical or other information about me to release to Medicare and/or commercial insurance and its agents any information needed to determine these benefits or benefits for related services. A photocopy of this release shall be considered effective and as valid as the original.

Payment in full may be required at the time of service. For your convenience, we accept personal checks, credit card, and cash. Any medical insurance you may have is intended to protect you against financial loss, but payment in full for your care is your responsibility regardless of insurance coverage.

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, authorized to furnish the information requested. I have read the above paragraph regarding payment of fees, and I understand that I am solely responsible for all charges incurred, regardless of insurance coverage or the liability of another party. I will make sure that my claims are paid promptly. A photocopy of this release shall be considered effective and as valid as the original.

Signature Patient/Guarantor/Guardian: Date:

- **CONSENT FOR CARE**
  I, or my representative, hereby consent to medical treatment, diagnostic and/or therapeutic services as ordered by my physician and his/her designee(s). I further understand that my physician may order an HIV antibody (AIDS) test as part of diagnosis and treatment.

  If I am an obstetrical patient admitted to the hospital for the delivery of my baby, I also consent to hospital care of my infant(s) encompassing diagnostic procedures, including but not limited to laboratory testing, and medical treatment.

  I understand that care may be provided to me by students performing under the supervision of hospital or medical staff.

  I understand that photographs or video may be used for identification purposes and to aid in or document my treatment. Photographs in the medical record will be handled according to customary medical record privacy practices.

  I understand that with the exception of physicians employed by the hospital, the physicians on staff at Stillwater Medical Center, such as emergency room physicians, radiologists, anesthesiologists, and pathologists are not employees or agents of the hospital but are independent contractors/agents who have been granted privileges to use the hospital facilities.

- **AUTHORIZATION TO RELEASE/OBTAIN INFORMATION FOR TREATMENT, PAYMENT, OR OPERATIONS; TO MY PATIENT PORTAL AND THE HEALTH INFORMATION EXCHANGE**
  I am aware that medical information will be released or obtained in order to get assistance in continued medical treatment, paying of bills or other routine operations of the hospital; to my patient portal and health information exchange. The information authorized for release may include records which may indicate the presence of a communicable disease or non-communicable disease. I have received a copy of the Notice of Information Practices (Privacy Notice) that describes how this information is used and may request another copy at any time**.**

- **AUTHORIZATION TO CONTACT**
  I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

- **INSURANCE PRE−CERTIFICATION**
  I hereby expressly understand I am responsible for notification to my insurance company to obtain authorization before service is rendered. I understand if this is not done, insurance benefits may be reduced.

- **VALUABLES AND PERSONAL BELONGINGS**
  Stillwater Medical Center is not responsible for personal valuables left at the bedside or retained on the person. This includes, but is not limited to electronic equipment, glasses, dentures, hearing or other prosthetic devices. (A HOSPITAL SAFE IS AVAILABLE FOR DEPOSIT OF VALUABLES UPON REQUEST).

- **PATIENT RIGHTS**
  I have read and received a copy of the Patient Rights. Patient Rights are posted in the Patients and Visitors Handbook available in each inpatient room and all outpatient−waiting areas.

- **ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, THIRD PARTY LIABILITY/AND BILLING**
  I, or legal guardian, assign and transfer all benefits, monies, and sums payable for hospitalization, sickness or accident under any hospitalization, (including major medical and supplemental benefits), sickness or accident policy providing for hospital payment.

  I, or legal guardian, will be responsible for any amount due in consideration of services rendered at Stillwater Medical Center. Amounts estimated or known to be payable by the patient become due and payable at the time of discharge (including, but not limited to, non−covered services, health insurance deductible, and coinsurance amounts). This includes hospital−based physicians and contractual physician services that may bill separately for their professional services.

  If this service is for treatment of an injury, illness or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, the patient agrees to give the hospital a lien, up to the amount of the outstanding charges, on any recovery the patient makes from the third party of any uninsured or underinsured motorist coverage of the patient, the patient's parents, patient's spouse, or patient's guardian. The patient further agrees that if there is no third party recovery or recovery from uninsured or underinsured motorist coverage, the patient, or legal guardian is still responsible for payment of the outstanding charges.

- **MEDICARE ASSIGNMENT OF BENEFITS**
  I, or representative, certify the information given in applying for payment under Title XVIII of the Social Security Act is correct. Release of information related to this Medicare claim to the Social Security Administration or its intermediaries and carriers is authorized. Request of payment of authorized benefits to Stillwater Medical Center is authorized.

- **MSG−−MEDICARE MESSAGE (Medicare Inpatient Only)**
  The federal government requires we provide to you written information regarding your rights as a Medicare hospital patient. You will receive information that includes the procedure for initiation, review, and resolution of complaints.

- **MSP QUESTIONNAIRE (Medicare Secondary Payor)**
  The government requires we request additional information from you to determine if there is any other resource for payment that could be primary to Medicare.

The undersigned certifies that he/she has read the above information or it has been explained so that he/she understands. Signatures also indicate he/she has been offered information on privacy and patient rights, including the procedure for initiation of complaints:

SIGNATURE OF PATIENT OR REPRESENTATIVE:	RELATIONSHIP TO PATIENT:	WITNESS:
RESPONSIBLE PARTY/INSURED (if different):	RELATIONSHIP TO PATIENT:	DATE:

Print Name_____ D.O.B_____

The Notice of Privacy Practices, which explains how your health information is protected, is available at the front desk. Please let us know if you have any questions regarding the Notice of Privacy Practices by contacting our front office, or discussing with your physician.

1. I do_____ do not_____ authorize messages containing medical information to be left on my voicemail at phone number_____
2. You may _____may not_____ call me and/or leave voicemail at my work number_____
3. You may discuss my medical information with the following people:
   Name_____ Phone_____
   Name_____ Phone_____
   Name_____ Phone_____

Your signature indicates that you are aware of the privacy practices at the Physicians Clinic.

_____/_____ _____ _____
Patient (or representative) signature Relationship to patient Date Time

Stillwater **Medical Center**
CLINICS

FEMALE ADULT MEDICAL PROFILE

PATIENT NAME	DATE OF BIRTH

Please list your allergies:

MEDICATION/FOOD	REACTION

Please list your current medications:

MEDICATION	DOSE (in mcg, mg, gm, etc)	HOW OFTEN?	NOTES

REVIEW OF SYSTEMS

Please check "Yes" if you had the symptom recently:

Yes

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Vision changes

RESPIRATORY
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

Yes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Edema
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Change in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Excessive urination
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

Yes

REPRODUCTIVE
- ☐ Abnormal Pap
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Vaginal discharge

INTEGUMENTARY
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair loss
- ☐ Excessive hairiness
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion

Yes

NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

METABOLIC & ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Yes

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

HEMATOLOGIC & LYMPHATIC
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph glands

IMMUNOLOGIC
- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

Stillwater **Medical Center**
CLINICS

Please complete the following:

MEDICAL HISTORY

	Condition	Date of Onset		Condition	Date of Onset
☐	Allergies		☐	Gallbladder disease	
☐	Anemia		☐	Acid reflux	
☐	Chest pain		☐	Headache - migraine	
☐	Anxiety		☐	Heart disease	
☐	Arthritis		☐	Heart valve disorder	
☐	Asthma		☐	Hepatitis/liver disease	
☐	Atrial fibrillation		☐	High blood pressure	
☐	Blood clots		☐	Irritable bowel disease	
☐	Cancer		☐	Heart attack	
☐	Cardiac arrhythmia		☐	Osteoporosis	
☐	COPD		☐	Kidney disease	
☐	Coronary artery disease		☐	Seizure disorder	
☐	Depression		☐	Stroke	
☐	Diabetes		☐	Thyroid disease	
☐	Elevated cholesterol				

Other:

SURGICAL HISTORY

	Procedure	Date		Procedure	Date		Procedure	Date
☐	Angioplasty		☐	Cataract extraction		☐	LASIK	
☐	Appendectomy		☐	Gallbladder surgery		☐	Mastectomy	
☐	Joint scope		☐	Colon surgery		☐	Uterine fibroid	
☐	Back surgery		☐	Colostomy		☐	surgery	
☐	Bilateral tubal ligation		☐	D&C		☐	Bone fracture repair	
☐	Blood transfusion		☐	Gastric bypass		☐	Thyroid surgery	
☐	Breast augmentation		☐	Hernia repair		☐	Tonsil surgery	
☐	Heart artery graft		☐	Hip replacement				
☐	Cardiac pacemaker		☐	Hysterectomy				
☐	Carpal tunnel release		☐	Knee replacement				

Other:

FAMILY HISTORY

	Condition	Relationship		Condition	Relationship
☐	ADD/ADHD		☐	Elevated cholesterol	
☐	Alcoholism		☐	Genetic disease	
☐	Allergies		☐	Hearing deficiency	
☐	Alzheimer's disease		☐	High blood pressure	
☐	Arthritis		☐	Irritable bowel disease	
☐	Asthma		☐	Learning disability	
☐	Blood disorder		☐	Mental illness	
☐	Cancer		☐	Migraines	
☐	Cardiovascular disease		☐	Obesity	
☐	Coronary artery disease		☐	Osteoporosis	
☐	CAD, premature		☐	Peripheral disease	
☐	Depression		☐	Kidney disease	
☐	Developmental delay		☐	Seizure disorder	
☐	Diabetes		☐	Stroke	
☐	Eczema		☐	Thyroid disorder	

☐ Other: _____

SOCIAL HISTORY

Tobacco

Have you ever used tobacco? ☐ No ☐ Yes

Type: _____

Usage: _____

Years: _____

Have you ever tried to quit? ☐ No ☐ Yes

Alcohol/Caffeine

Do you drink alcohol? ☐ No ☐ Yes

Do you drink/consume caffeine? ☐ No ☐ Yes

Lifestyle

Activity Level ☐ Moderate ☐ Sedentary ☐ Vigorous

To submit this form, please save a copy and e-mail it to smpc-info@stillwater-medical.org