Patient Registration Form

First Name: ____

Middle Name: ____

Last Name: ____

Prefix (Mr, Ms, Mrs, etc.): ___________ Suffix (Sr, Jr, III, etc.): ___________

Date of Birth _____/_____/_________

Over 18 Years of Age? **Yes** ☐ **No** ☐ Sex/Gender **Male** ☐ **Female** ☐

Phone Number ____

Is this a mobile phone number? **Yes** ☐ **No** ☐

Address (No P.O. Box) ____

Apartment Number ____

City __________________________________ State __________ Zip ___________

Is this your mailing address? **Yes** ☐ **No** ☐

If No:

Address (No P.O. Box) ____

Apartment Number ____

City __________________________________ State __________ Zip ___________

Are you a veteran? **Yes** ☐ **No** ☐

Are you on Medicare, Medicaid, or SoonerCare? **Yes** ☐ **No** ☐

Are you currently or do you plan to become pregnant? **N/A** ☐ **Yes** ☐ **No** ☐

Do you currently or do you plan to breastfeed? **N/A** ☐ **Yes** ☐ **No** ☐

Patient History

Please notify the staff if you have any questions or need help in filling out this questionnaire.

Who is filling out this Form?

- ☐ Patient
- ☐ Other (Your relationship to patient): ____

Medical Conditions:

Please list all your medical conditions below.

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Allergies:

Please list all your allergies below.

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Medications:

Please list all your current medications below.

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S 164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment; a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

____

Signature of Patient or Legal Guardian

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Printed Patient Name

Note: *This document is a template only. It does not reflect the requirements of your state 's laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state 's privacy laws prior to using this document*.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;

Consent to Treatment

I hereby give my permission for **ERIK E. PAULSON, D.O.** (the Practice) to give me medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive. I understand that:

- The Practice will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

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Signature of Patient or Legal Guardian

____

Printed Patient Name

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **ERIK E. PAULSON, D.O.** (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alterative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____

Printed Patient Name

Note: *This document is a template only. It does not reflect the requirements of your state 's laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state 's privacy laws prior to using this document.*