GET WELL CENTER
PATIENT REGISTRATION

Date:____________________ Please circle one

Patient's Personal Information: (Marital status) Single Married Divorced Widowed (Sex) Male Female

Name:_________________________ _________________________ ______ **Date of Birth:**______________
Last First Initial

SSN#________________________ **How do you wish to be addressed ?**____________________________

Address:____________________________ **Apt#**__________ **City:** __________________**State:**_______ **Zip:**________

Home phone (_____)____________________ **Alt phone (_____)**______________________

Employer Name, Address, Phone____

Occupation____ **Full time** **Part time**

Spouse's name:________________________________ **Spouse's phone #**_________________**DOB:**______________

Spouse's Employer:______________________________ **Employer Phone:**________________________________

Patient's / Responsible Party Information:

Relationship to patient: Self Spouse Other (If self, skip to next section)

Responsible party name:____________________________ **DOB:**___________________**SSN #**____________________

Address:____________________________**APT#**__________**City:**_________________**State:**_________**Zip:**________

Phone:_______________________

Employer's Name, Address, Phone____

Patient's Insurance Information:

Primary Insurance Co:______________________ **Address:**____________________________**Phone:**______________

Insurance ID #:_________________________________ **Group #:**_______________________

Insured Name:___________________________ **DOB:**__________**Relationship to Patient:**____________________

Secondary Insurance Co:____________________________ **Address:**____

Phone:_____________________ **Insurance ID #:**__________________________________**Group #:**_______________

Insured Name:___________________________**DOB:**__________**Relationship to Patient:**____________________

Patient's Referral information: Please circle one

Referred By:______________________________ **May we thank him or her ? YES NO**

Name(s) of other Physicians who care for you:

____

Emergency Contact Information:

Name of Person not living with you : ____________________________________ **Relationship:** _______________

Address:________________________________**City:**______________________**State:**___________**Zip:**___________

Phone : (_____)______________________ **Alt Phone:(_____)**________________________

Signature:____________________________________ **Date:**________________________

GET WELL CENTER

New Patient Medical History

Name: ______________________________ Date of Birth: ___/___/______ Age: ____ Sex: ____

How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

Past Medical History					
Cancer	Y / N	MI/ Heart attack	Y / N	Anxiety	Y / N
Heart disease	Y / N	High Blood Pressure	Y / N	Depression	Y / N
Kidney disease	Y / N	High Cholesterol	Y / N	HIV	Y / N
Thyroid disease	Y / N	Stroke	Y / N	Hepatitis A, B, C	Y / N
Arthritis	Y / N	Epilepsy/ Seizures	Y / N	GERD	Y / N
COPD/ Emphysema	Y / N	Anemia	Y / N	Stomach ulcers	Y / N
Asthma	Y / N	Diabetes	Y / N	Osteoporosis	Y / N
Pneumonia	Y / N	Glaucoma	Y / N		Y / N

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*

♦ Social History ♦		
Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
Average smoked per day?	Caffeine?	How much caffeine per day/ week?
Have you used recreational substances in the past 2 years ?		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and check mark those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Change in appetite
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	Difficulty urinating	Fatigue
Nosebleeds	TB exposure	Vomiting	Easy bruising	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Back pain	Hot Flashes
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*		*Month/Yr*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Chest X-Ray	

GET WELL CENTER

635 S. TRIMBLE RD.

MANSFIELD, OH 44906

(419) 524-2676

FINANCIAL POLICY / ASSIGNMENT OF BENEFITS

Please remember to bring your insurance card to each visit and let us know if there are any changes to your billing information and also any address or phone number changes. We want to ensure that your visit with us is a pleasant experience. Please remember that the patient is responsible for the charges incurred

Payment

A statement of fees will be sent to you on a monthly basis. Once your insurance has payed on the claim, the remaining balance will be your responsibility. If you need to make special arrangements for payments, please contact our billing department at (855) 255-1037 or our office directly at (419) 524-2676.

Self-Pay Patients

Payment is due at the time of service.

Insurance

We participate in a variety of health care insurance programs, which aid in payment of your medical costs. You will need to contact your carrier to see if we are in or out of network. Should there be any problems with an insurance claim, we suggest you first contact your insurance carrier. Our billing company would also be happy to assist you in resolving any problems.

Co-Payments

All co-pays are due at the time of service.

Medicaid

If you are receiving Medicaid benefits, please plan to present your current card prior to each visit.

Assignment of Benefits

I request that payment of authorized Commercial Benefits, Medicare, Secondary Medicare or Medicaid coverage benefits be made directly to D & I Associates/ DBA Get Well Center for any services rendered. I understand that I am financially responsible for charges whether or not they are covered by insurance. I authorize this Healthcare provider to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for related services.

Patient signature: ______________________________ **Date:** ________

GET WELL CENTER HIPPA AUTHORIZATION FORM FOR FAMILY MEMBERS/ FRIENDS

I, ________________________________, give permission to the Get Well Center to disclose and release my protected health information described below to:

Name(s):	Relationship:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Health Information to be disclosed (check all that apply):

- o My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- o My complete health record, as above, with the exception of the following information: (Check as appropriate)
  - o Mental health records
  - o Communicable diseases (including HIV and AIDS)
  - o Alcohol/Drug abuse treatment
  - o Other (please specify____

    ____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- o All past, present, and future periods, OR
- o Date or event ____

  Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying the Get Well Center in writing.)

____

Name of individual giving this authorization

____________________________________ ____________________

Signature of individual giving this authorization Date