Patient Registration

Patient Information

Full Name: ____ Preferred Name: _______________________

Address: _____________________________ City: _______________ State: _______ Zip: ___________

Birthdate: __________________ Sex: M or F Marital Status: S M D W SSN:________________

Home Phone: _______________ Cell Phone: ________________ Work Phone: _________________

Employer: _______________________________ E-mail: __________________________________

Responsible party

Full Name: _______________________________ Birthdate: _____________ SSN: _________________

Address: _____________________________ City: ______________ State: _______ Zip: ____________

Phone: _________________ Employer: _______________________ Work Phone: _______________

Insurance Information

Primary Ins: _____________________ Policy ID #: _______________________ Group #: __________

Subscribers Name: ___________________________________ Subscribers DOB: __________________

Secondary ins: ___________________________ Policy Number: ___________________ Group #: ___________

Subscriber: _________________________________ Subscribers DOB: __________________________________

Relationship to patient: ______________________________Effective date:

Emergency Contacts

Name: ____________________________ Phone #: ___________________ Relationship: __________________

Name: ____________________________ Phone #: ___________________ Relationship: __________________

I authorize my provider to act as my agent in assisting me in obtaining payment from insurance for services rendered, the release of any medical information necessary to process insurance claims, and payment of medical benefits directly to the provider for services rendered.
I understand that I am responsible for all co-payments, coinsurance, and services deemed "non-covered" by my insurance.

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SIGNATURE OF PATIENT/GUARDIAN DATE

HIPAA Compliance Information

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that records may be accessible to necessary entities to provide care and for administrative purposes. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment

3. The practice utilizes multiple vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. We will notify you of any breach in your unsecured PHI

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law; including court or administrative ordered subpoena or discovery request
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence

- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls
- To your employer when we have provided health care to you at the request of your employer
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law
- If necessary; coroners, funeral directors or to arrange an organ or tissue donation or transplant
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination and/or FMLA.

5. You have the right to bring any concerns or complaints regarding privacy to the attention of the provider or clinic staff.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address.

Quentin N. Burdick United States Courthouse	Christina Dahl, NP-C, BC-ADM (Privacy Officer)
U.S. Attorney's Office	Diabetes Care Clinic
655 First Avenue North, Suite 250	1665 43rd St. S. Suite 102
Fargo, ND 58102-4932	Fargo, ND 58103
Phone: 1-888-716-7395	Phone: 701-540-9822
Fax: (701) 297-7405	Fax: (701) 540-9824

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

I do hereby acknowledge that I have received and read the *HIPAA COMPLIANCE INFORMATION* form. I agree and consent to the terms set forth in the document and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Printed Name: ____ Date: ________________

Signature: ____

Consent for Reminders, Messages, and Sharing of Information

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

This consent was signed by (printed name):____

Signature: ____ Date: __________________

Witness:____ Date: ___________________

NEW PATIENT

MEDICAL HISTORY FORM

Full Name: ___________________________________ DOB: __________________

Allergies: ☐ No Known Allergies

Allergy	Reaction

Medications: ☐ None Preferred Pharmacy: _______________________ Location: _____________

Medication	Dose	Frequency

Personal Medical History:

Disease/Condition	Year Diagnosed	Current	Past	Comments
Diabetes Type:				
High Blood Pressure				
High Cholesterol				
Heart/Vascular				
Stroke				
Kidney				
Thyroid (ie: hypothyroid, graves)				
Gastrointestinal (ie: celiac, pancreatitis)				
Mental Health (ie: depression, anxiety)				
Addiction (alcohol, drug use)				
Cancer Type:				
Other:				
Other:				
Other:				

Surgical History: ☐ None

Type	Date	Location/Facility

Family Medical History:

✓ Check all that apply	Diabetes List Type	High Blood Pressure	High Cholesterol	Heart Disease	Stroke	Kidney Disease	Mental Health	Cancer List Type	Other:
Mother									
Father									
Brother									
Sister									
Child									
Maternal G. Mother									
Maternal G. Father									
Paternal G. Mother									
Paternal G. Father									
Other:									
Other:									

Social History:

Occupation:	☐ Retired ☐ Unemployed ☐ Disabled
If employed, do you work the night shift?	☐ No ☐ Yes Work hours:
Tobacco Use:	Smoke cigarettes? ☐ Yes ☐ No
Current: Packs/day: # of years:	*Past:* Quit date: Packs/day: # of years:
Other tobacco:	☐ Pipe ☐ Cigar ☐ Snuff/Chew How often?
Alcohol Use:	Do you use alcohol? ☐ No ☐ Yes ☐ Beer ☐ Wine ☐ Liquor # per week
Drug Use:	Do you use marijuana or recreational drugs? ☐ No ☐ Yes How often:

Health Maintenance:

Exercise:	Do you exercise regularly? ☐ No ☐ Yes
What kind of exercise?	***Duration**:* How long (min): How often:
Sleep:	On average, how many hours do you sleep/day? Do you feel well rested? ☐ No ☐ Yes
Diet:	How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

Health Screenings and Immunizations:

Item	Date	Facility/Provider	Results
Diabetic Eye Exam			
Lipid Testing			
Urine Albumin Testing			
Influenza Vaccine			
Pneumonia Vaccine			

Other Providers/Specialist:

Provider	Name	Last Visit
Primary Care		
Cardiology		
Ophthalmology		
Nephrology		
Other:		
Other:		

Additional information that you would like to share with us: