CLS HEALTH

PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

DATE: _____

Legal Name: First _____ MI _____ Last _____ Preferred Name: _____

Parent / Legal Guardian Name: _____ DOB: _____ Mobile: _____

SS# (optional): _____ DOB: _____ Legal Sex: ❑ M ❑ F

Do you have any Sexual Orientation or gender preferences you would like us to consider? ❑Yes ❑ No

Is your Legal Sex different from your Assigned Sex at Birth? ❑ Yes ❑ No

If you answered yes to either of these questions, additional information will be collected from you later.

Address: _____ Apt# _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Email _____ ❑ No Email

GENERAL INFORMATION

Marital Status ❑ Divorced ❑ Legally Separated ❑ Married ❑ Significant Other ❑ Single ❑ Widowed

Need Interpreter ❑ Yes ❑ No Preferred Language _____ Written Language _____

Race: ❑ Asian ❑ Black ❑ Native American ❑ Native Hawaiian/Pacific Islander ❑ Two or More Races ❑ White

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

ADDITIONAL DEMOGRAPHICS

Do you have any communication difficulties / special needs? Visually Impaired: ❑Y ❑N Hearing Impaired: ❑Y ❑N Special Needs: ❑Y ❑N

If yes, please list: _____

PCP

Primary Care Physician _____ ❑ No Primary Care Physician

EMERGENCY CONTACTS

Name _____ Relationship to Patient _____ Home Phone _____ Mobile _____

Name _____ Relationship to Patient _____ Home Phone _____ Mobile _____

EMPLOYMENT

Employer Name _____ Employment Status: ❑Disabled ❑ Full Time ❑Part Time ❑Retired ❑ Student ❑ Unemployed

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

❑ **Only Release Information to Patient**
If *no* answer, may we leave a message on your: Home Phone ❑Y ❑N Work ❑Y ❑N Mobile ❑Y ❑N

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑Y ❑N Mobile _____ May We Leave a Message? ❑Y ❑N

You may release the information regarding the following services to the person named above: ❑ Appointments ❑ Billing ❑ Medical Care

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑Y ❑N Mobile _____ May We Leave a Message? ❑Y ❑N

You may release the information regarding the following services to the person named above: ❑ Appointments ❑ Billing ❑ Medical Car

FINANCIALLY RESPONSIBLE PARTY - GUARANTOR

❑ **Same as Patient Information (If different, please complete section below)**

Name: First _____ MI _____ Last _____ DOB _____

Relationship (Please circle): Spouse Father Mother Other (Please Specify) _____

Address: _____ Apt# _____ City _____ St _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑Student ❑Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ Sex: ❑M ❑F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑Student ❑Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

SECONDARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ Sex: ❑M ❑F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ Employment Status: ❑Student ❑Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

Pharmacy Name _____ **Pharmacy Location** _____

CONSENTS FOR MINORS (Only fill out if patient is ages 0-18)

Phone #: _____

Consent for Treatment: I, as the legal guardian, authorize to CLS Health to treat the minor named above ❑ Yes

Consent for Third-Party Accompaniment: When I can't accompany my child to CLS Health for care, I authorize the adult (over 18) named below to obtain their medical care and access related information about appointments, insurance, test results, and medical matters.

Name _____ DL #: _____ Relationship _____ Phone _____

ACKNOWLEDGEMENT OF ACCURACY:

By signing this form, I acknowledge and agree to the following: I, as the responsible party, have entered the information in the patient registration form accurately and truthfully to the best of my knowledge.

Patient/Guardian Name: _____ Signature: _____ Date: _____

CLS HEALTH

PATIENT ACKOWLEDGEMENTS & AGREEMENTS

Acknowledgements & Agreements

By signing, I acknowledge and agree to the following:

- I, as the responsible party, have entered the information in the patient registration form accurately and truthfully to the best of my knowledge.
- I have received or had the opportunity to read the CLS Health Patient Care Guide understanding my rights, responsibilities, and CLS Health's policies.
- I will seek clarification on any unclear details and can request the CLS Health Patient Care Guide at any time.
- I consent to the guide's practices and acknowledge CLS Health will retain this form in my records.

Patient/Guardian Name: _____ Signature: _____ Date: _____

CLS HEALTH

Podiatry New Patient Form

New Patient Information - Patient History

Patient Name: _____ DOB: _____ Sex: _____ Date: _____

Reason for today's visit: _____

High Blood Pressure	Asthma	Jaundice	Arthritis
Coronary Artery Disease	Other Lung Problems	Deep Vein Thrombus	Back Injury
Heart Failure	Tuberculosis	HIV	Depression
Heart Attack	Ulcers	Sickle Cell	Psychiatric Illness
High Cholesterol	Diverticulitis	Bleeding Disorders	Glaucoma
Diabetes	Gallstones	Anemia	Eye Problems
Thyroid Problems	Hernias	Kidney Stones	Cancer
Pulmonary Embolus	Cirrhosis	Urinary Problems	Sleep Apnea

Current Medications (name/dosage)

Please include IV antibiotics, nebulizer medications, vitamins, over the counter and prescription meds.

_____

_____

_____

_____

Medication Allergies (list & explain) or ( ) None

_____

Family History of Medical Problems:

( ) None ( ) Heart Disease ( ) Diabetes ( ) Cancer ( ) TB ( ) Hypertension ( ) Stroke ( ) Thyroid ( ) Other

Mother: _____ Father: _____

Siblings: _____ Children: _____

Past Surgeries (Type & Date) ☐ None

_____

Hospitalizations (Type & Date) ☐ None

_____

Immunizations / Vaccines: ☐ Pneumonia ☐ Hep A ☐ Hep B ☐ Flu Shot ☐ Tdap ☐

Other_____

Have you ever smoked? ☐ Yes ☐ No Packs per day ____ Years ____ Quit? _____

Do you drink alcohol? ☐ Yes ☐ No Drinks per Week ____ ☐ Wine ☐ Beer ☐ Liquor

Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____) _____ **ALT. PHONE** (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**