

**PORTSMOUTH COMMUNITY HEALTH CENTER, INC.
PARK PLACE MEDICAL CENTER**

PATIENT REGISTRATION FORM

HEALTH CENTER LOCATION:

Lincoln Street, Portsmouth, VA ____
Park Place Medical Center, Norfolk VA ____

DATE: _____

PATIENT LAST NAME: _____ FIRST: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: (H) _____ - _____ - _____ SOCIAL SECURITY #: _____ - _____ - _____

DOB: _____ AGE: _____ SEX: M OR F

PATIENT LABE RESULTS/EMERGENCY CONTACT

(1) EMERGENCY CONTACT: _____ RELATIONSHIP _____

HOME OR CELL PHONE: _____ - _____ - _____

EMAIL ADDRESS : _____

(2) EMERGENCY CONTACT: _____ RELATIONSHIP _____

HOME OR CELL PHONE: _____ - _____ - _____

EMAIL ADDRESS : _____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE: _____

PHONE: _____ - _____ - _____

GROUP NUMBER: _____ POLICY NUMBER: _____

SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____

PHONE: _____ - _____ - _____

GROUP NUMBER: _____ POLICY NUMBER: _____

SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYER: _____ EFFECTIVE DATE: _____

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I hereby authorize treatment by physicians of PCHC as well as release of medical information to any of my physicians or my insurance companies that may be pertinent to my case. I hereby authorize payment directly to PCHC of benefits otherwise payable to me. I understand that I am financially responsible for charge not covered by this authorization. I certify that all the above information is true and correct to the best of my knowledge. I understand that I must report any income changes and that I will lose Sliding fee Scale rights if I do not. I also understand that my sliding fee scale status will be subject to, at minimum, of being periodically reviewed for updating my financial information.

SIGNATURE

DATE

**PORTSMOUTH COMMUNITY HEALTH CENTER, INC.
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HEALTH SURVEY

NAME: _____

CHART #: _____

Your answers to these questions will help your doctor understand your current personal profile in order to make informed medical decisions and help you be as healthy as possible. Please answer each question as accurately as possible.

All information is strictly confidential.

Birth date: ____/____/____

Single Separated Married
Divorced Widowed

Place of Birth: _____

Are you currently employed? _____ If so, what is your occupation: _____

Education (Highest grade attended) _____

1. Do you use tobacco? Yes No
(cigarettes, cigars, snuff, chew)

I quit in _____ (year). If yes, how much per day? _____

2. Do you drink alcoholic beverages? Yes No

I quit in _____ (year). If yes, how much per day? _____

3. Have you ever used narcotics, Yes No
intravenous, or other drugs?

I quit in _____ (year). If yes, how much per day? _____

4. Do you get out of bed yourself? Yes No

5. Do you dress yourself? Yes No

6. Do you make your own meals? Yes No

7. Do you do your own shopping? Yes No

8. When was your last eye exam? _____

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WRITTEN ACKNOWLEDGEMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____, have been provided a copy of the Medical Practice's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Medical Practice if I do not understand any information contained in the Notice of Privacy Practices.

Patient Signature

Date

Authorized Representative of Patient

Relationship to Patient

Date

Disclosures to Family Members and Friends

_ Disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services based upon permission of the patient.

Disclosures are not guaranteed. We are under no obligation to discuss health or billing information by the telephone with your family members or friends. If we do agree to release this information, we will only disclose information relevant to current treatment.

Please list below the individuals permitted to receive information about your current medical treatment or billing information. **Note: All telephone callers will be asked to provide a password of your choice for security purposes.**

My mother's maiden name?

_____.

What was the name of my first pet?

_____.

<u>Relationship</u>	<u>Name</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____

Date: _____

Patient Legal Rep.: _____

Relationship: _____