Raincross Medical Group, Inc.
The Cure For The Common Practice

NEW PATIENT REGISTRATION

Name: _____
First Name *Middle Name* *Last Name*

Date of Birth: _____ / _____ / _____ **Gender:** Male Female Non-Binary
Month *Day* *Year* *Circle One*

Marital Status: _____ **Social Security Number:** _____ - _____ - _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

***Email Address:** _____
**By providing your email address, you are electing to receive email communication from Raincross Medical Group and its affiliates.*

Primary Language: _____

Race: (Circle One) American Indian Asian African American White Other: _____

Employment Status: (Circle One) Full-Time Part-Time Unemployed Retired

Employer: _____ **Occupation:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: _____ **Relationship:** _____

Cell Phone: _____ **Home Phone:** _____

I hereby give my permission to contact the above mentioned individual if I cannot be reached. I further give my permission for any treating physician or physician's representative to speak with this person regarding me or my medical condition including but not limited to lab / pathology / diagnostic test result. **Circle One: YES or NO**

Primary Insurance: _____

Group Number: _____ **Policy/ID Number:** _____

Secondary Insurance: _____

Group Number: _____ **Policy/ID Number:** _____

Primary Insurance Subscriber: _____ **Relationship:** _____

Date of Birth: _____ **Social Security Number:** _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that ***I am responsible for knowing my benefits/coverage and tests ordered by my physician may NOT be covered****. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. Raincross Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Raincross Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I here- by acknowledge that I have read, understand and agree to hereby give consent for treatment.*

Patient Signature: _____ **Date:** _____

HEALTH HISTORY

Name: _____ **Date of Birth:** _____

Previous Primary Care Physician: _____

City: _____ **Phone #:** _____ **Fax #:** _____

ALLERGIES: Any known drug allergies? *(Circle One)* **YES NO**
Please list all allergies including food, medications and environmental and reaction.

PREFERRED PHARMACY: _____

Address: _____ **Phone Number:** _____

Do you currently take any **medications** on a regular basis? (*Circle One)* **YES NO**
If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

MEDICATION	**DOSE**	**FREQUENCY**

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

MEDICAL HISTORY:

Illness & Conditions	**Surgical History OR Hospitalizations**

GYNECOLOGICAL HISTORY (women only):

Last Menstrual Period: _____

Number of Pregnancies? _____

Number of children? _____

Have you had an abnormal pap smear? _____

Have you had a hysterectomy? _____

Have your ovaries been removed? _____

SEXUAL HISTORY:

Do you have sex with: MEN WOMEN BOTH

Have you had an HIV test? YES NO

FAMILY HISTORY:

Do you have any family history of serious illnesses? If yes, please list them below and indicate which family member. (ie. Hypertension, diabetes, colon cancer, breast cancer)

SOCIAL HISTORY:

Marital Status: *(Circle One)* Single Married Partnered Co-habiting Separated Divorced Widowed

Do you have children/dependents at home? *(Circle One)* YES NO How many? _____

Are you employed? *(Circle One)* YES NO Occupation? _____

What is your highest level of education? *(Circle One)* High School College Graduate School

Do you of have you ever smoked, vaped or chewed tobacco? *(Circle One)* YES NO

If yes, when? _____ Quit Date: _____ #packs per day _____ for _____ years

Do you drink alcohol? *(Circle One)* YES NO Type? _____ How often? _____

Do you drink caffeine? *(Circle One)* YES NO Type? _____ How often? _____

Do you exercise? *(Circle One)* YES NO Type? _____ How often? _____

Do you have a living will or advance directive? *(Circle One)* YES NO

If there anything else you would like us to know about your health? _____

_____

HIPAA NOTICE OF PRIVACY PRACTICES

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services. Office of Civil Rights, about violations of the provisions of the notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint you may contact:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-800-368-1019
www.hhs.gov

PATIENT'S RIGHTS & RESPONSIBILITIES

Rights	Responsibilities
• To receive service in a reasonable period of time. • To receive medically necessary service. • To be treated with respect and courtesy. • To receive available information about your care and treatment, including risks and options. • To have your medical coverage explained to you. • To participate in treatment decisions. • To refuse treatment. • To receive impartial access to treatment. • To receive a second opinion regarding any treatment plan. • To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges. • To request review of your medical record by the physician, and to request corrections if necessary. • To be given information on how to file a complaint/grievance. • To formulate an advance directive if you have a life-threatening illness or injury.	• Having appropriate identification, insurance membership cards, etc at the time of appointment. • Keeping appointments or contacting the office in advance to cancel an appointment. • Fulfilling financial obligations at the time of service such as deductible or co-pay fees. • Providing complete and accurate information. • Following the health plan you and the physician agree on. • Being considerate of others. • Providing legal documentation of guardianship for a minor being treated. • Providing a list of person(s) who may receive medical information about you, on your behalf, in an emergency.

AUTHORIZATION TO RELEASE INFORMATION

Your personal medical information will **NOT** be released to anyone except as detailed in the HIPPAA Notice of Private Practices unless you give written permission stating otherwise.

I give permission to disclose my medical information to the following:

1. **Recipient Name:** _____

   Relationship: _____ **Phone:** _____

2. **Recipient Name:** _____

   Relationship: _____ **Phone:** _____

3. **Recipient Name:** _____

   Relationship: _____ **Phone:** _____

I have read and understand the *HIPAA Notice of Privacy Practices* and *Patient's Rights and Responsibilities* as stated above. These policies may change from time to time. I may request a current copy of this form at any time. I also agree to release (or not to release) information as per the Authorization to Release Information Section.

Patient Name: _____

Signature: _____ **Date:** _____