# Waverly Primary Care
## REGISTRATION FORM

| Today's Date: | PCP: Dr. Zhang Dr. Foster Dr. Brundle |
|---|---|

**PATIENT INFORMATION**

| Last name: First: | Middle: | Marital status: |
|---|---|---|

| Is this your legal name? ○ Yes ○ No | If not, what is your legal name? | Ethnicity: | Birth date: | Age: | Sex: ○ M ○ F |
|---|---|---|---|---|---|

Address: [Address/ P.O Box, City, ST, ZIP Code]

| Social Security #.: | Home phone #.: | Cell phone #.: |
|---|---|---|
| Occupation: | Employer: | Employer phone #.: |

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE FRONT DESK)**

| Person responsible for bill: Self / other: | Birth date: | Address (if different): | Home phone #.: |
|---|---|---|---|
| Is this person a patient here? ○ Yes ○ No | | Is this patient covered by insurance? ○ Yes ○ No | |

Please indicate primary insurance: Secondary:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
|---|---|---|---|---|---|

Patient's relationship to subscriber: (Circle one) Self Spouse Child Other :

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

**IN CASE OF EMERGENCY**

| Emergency Contact: | Relationship to patient: | Home phone #.: | Cell #: |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Waverly Primary Care or insurance company to release any information required to process my claims.

Patient signature _____ Date _____

*Waverly Primary Care*

## Health History Questionnaire

Date:_____

Name_____ Date of birth_____

Address_____

Phone number_____

Please describe what problem or concern brought you to our office today:_____

_____

| Special Communication Needs: | | | |
|---|---|---|---|
| Language preference: | | | |
| If 'yes' to any of the questions below, how can we assist? | | | |
| Visual impairment | ☐ Yes ☐ No | Cognitive impairment | ☐ Yes ☐ No |
| Hearing impairment | ☐ Yes ☐ No | Sensory impairment | ☐ Yes ☐ No |
| Speech impairment | ☐ Yes ☐ No | Other: | |

| Personal Health History | | | |
|---|---|---|---|
| Please put **(P)** for **Past** or **(C)** for **Current** problems/conditions | | | |
| Condition | | Condition | |
| ☐ Hypertension | | ☐ Seizures | |
| ☐ High cholesterol | | ☐ Headaches | |
| ☐ Diabetes | | ☐ Stroke | |
| ☐ Heart attack or angina | | ☐ Prostate problem | |
| ☐ Irregular heart rhythm | | ☐ Breast problem | |
| ☐ Congestive heart failure | | ☐ Urinary tract infections | |
| ☐ Asthma | | ☐ Osteoarthritis | |
| ☐ Emphysema/chronic bronchitis | | ☐ Cancer (Please list type) | |
| ☐ Pneumonia | | ☐ Thyroid problem | |
| ☐ Gastroesophageal reflux disease | | ☐ Bleeding disorder | |
| ☐ Stomach ulcer | | ☐ Addiction Issues | |
| ☐ Kidney problems | | ☐ Depression or anxiety | |
| ☐ Liver disease/hepatitis | | ☐ Mental Illness | |
| ☐ Colon cancer | | ☐ Other (please describe) | |
| ☐ Bowel/digestive problem | | | |

| **Previous** Surgical Procedures | |
|---|---|
| Please check if you have had any of the following | |
| Procedure | Year |
| ☐ Heart surgery | |
| ☐ Carotid artery surgery | |
| ☐ Vascular surgery / stent | |
| ☐ Abdominal aneurysm repair | |
| ☐ Hysterectomy | |
| ☐ Gallbladder removed | |
| ☐ Appendix removed | |
| ☐ Tonsillectomy | |
| ☐ Joint replacement | |
| ☐ Breast cancer surgery | |
| ☐ Prostate cancer surgery | |
| ☐ Hernia | |
| ☐ Pacemaker | |
| ☐ Other (please describe) | |

| Social History: |
|---|
| Please circle appropriate answers below and provide explanations where appropriate |
| Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner |
| Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher |
| Occupation: Occupational concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting |
| How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful |
| Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, describe below |
| Are there any religious or cultural factors that you would like us to take into account when planning your healthcare? |

## Review of Systems

Please check problems or conditions that you are **CURRENTLY** experiencing

| | | | |
|---|---|---|---|
| ☐ Chest pain | ☐ Rectal bleeding | ☐ Eye pain | ☐ Nervousness |
| ☐ Shortness of breath | ☐ Black/tarry stools | ☐ Loss of vision | ☐ Pain in testicles |
| ☐ Wheezing | ☐ Weight loss | ☐ Double vision | ☐ Loss of libido |
| ☐ Cough | ☐ Weight gain | ☐ Memory loss | ☐ Impotence |
| ☐ Coughing up blood | ☐ Loss of appetite | ☐ Ringing in ears | ☐ Breast pain |
| ☐ Sore throat | ☐ Difficulty swallowing | ☐ Pain in ears | ☐ Breast discharge |
| ☐ Nasal congestion | ☐ Diarrhea | ☐ Nose bleeds | ☐ Other (please describe below) |
| ☐ Irregular heartbeat | ☐ Constipation | ☐ Hoarseness | |
| ☐ Fast heartbeat | ☐ Painful urination | ☐ Easy bleeding | |
| ☐ High blood pressure | ☐ Blood in urine | ☐ Easy bruising | |
| ☐ Low blood pressure | ☐ Urine frequency | ☐ Rash | |
| ☐ Lightheadedness | ☐ Decrease in urine flow | ☐ Changes in mole | **Females - Please complete** |
| ☐ Dizziness/fainting | ☐ Urine leakage | ☐ Sore that won't heal | Menstrual flow: |
| ☐ Abdominal pain | ☐ Headache | ☐ Fatigue/lethargy | ☐ Reg. ☐ Irreg. ☐ Pain/cramps |
| ☐ Heartburn | ☐ Weakness | ☐ Insomnia | Days of flow __ Length of cycle__ |
| ☐ Indigestion | ☐ Loss of strength | ☐ Forgetfulness | 1st day of last period _____ |
| ☐ Ankle swelling | ☐ Balance problems | ☐ Depression | ☐ Pain or bleeding after sex |
| ☐ Nausea | Pain, weakness, or numbness in | | Number of pregnancies ___ |
| ☐ Vomiting | ☐ Arms ☐ Hips ☐ Back | | Miscarriages___ |
| ☐ Vomiting blood | ☐ Legs ☐ Neck ☐☐ Shoulders | | Birth control method _____ |
| ☐ Change in bowel habits | ☐ Hands ☐ Feet | | |

**List brother or sister under siblings & daughter or son under children below**

| Relationship | Living Y/N | Age | Major Medical Problems and/or Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| **Siblings** | | | |
| | | | |
| | | | |
| **Children** | | | |
| | | | |
| | | | |

Specifically have any of your relatives had the following conditions

| Condition | Relative | Condition | Relative |
|---|---|---|---|
| ☐ Mental illness | | ☐ Chemical dependency | |

## Allergies:

Please list any allergies to medications or foods

| | |
|---|---|
| | |
| | |
| | |

| **Hearing Screening:** Circle Yes, No or Sometimes | | | |
|---|---|---|---|
| 1. Do you have trouble hearing the TV or radio when others do not? | Yes | No | Sometimes |
| 2. Do you have to strain or struggle to hear/understand conversations? | Yes | No | Sometimes |

| Medications: | |
|---|---|
| Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency | |
| | |
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| | |

| Health Maintenance: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Please check whether you have had the following preventive services and enter the year of the service | | | | | | | |
| Immunizations | | | Year | | Tests | | Year |
| Tetanus vaccine / Tdap | ☐ Yes | ☐ No | | | Pap smear/pelvic | ☐ Yes ☐ No | |
| Pneumonia vaccine | ☐ Yes | ☐ No | | | Mammogram | ☐ Yes ☐ No | |
| Influenza vaccine | ☐ Yes | ☐ No | | | Bone Dexa | ☐ Yes ☐ No | |
| Shingles vaccine | ☐ Yes | ☐ No | | | Colonoscopy | ☐ Yes ☐ No | |
| | | | | | Prostate test | ☐ Yes ☐ No | |

| Specialty Providers: | |
|---|---|
| In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them | |
| ☐ Eye doctor | ☐ Nephrologist |
| ☐ Cardiologist | ☐ Psychiatrist |
| ☐ Oncologist | ☐ Allergist |
| ☐ Urologist / Gynecologist | ☐ Vascular |
| ☐ Gastroenterologist | ☐ Pulmonologist |
| ☐ Endocrinologist | ☐ Other |

| Health Behaviors: | | | | |
|---|---|---|---|---|
| Tobacco use: ☐ Never ☐ Current smoker Started_____ Packs per _____/Day_____/Week | | | | |
| ☐ Quit (when)_____ | | | | |
| Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____/Day_____/wk Wine / Beer / Liquor | | | | |
| Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current | | | | |
| If past or current drug use describe: | | | | |
| Exposure to secondhand smoke | ☐ Yes | ☐ No | Wear a seatbelt | ☐ Yes ☐ No |
| Eat a diet high in fruits and vegetables | ☐ Yes | ☐ No | See a dentist at least once a year | ☐ Yes ☐ No |
| Get 30 minutes of exercise 5 times a week | ☐ Yes | ☐ No | Wear sunscreen | ☐ Yes ☐ No |

| Advance Care Planning: | | | |
|---|---|---|---|
| Do currently have, or would you like information on, any of the following items | | | |
| Living Will: | ☐ Have | ☐ Don't Have | ☐ Want Information |
| Durable Power of Attorney: | ☐ Have | ☐ Don't Have | ☐ Want Information |
| DNR Order: | ☐ Have | ☐ Don't Have | ☐ Want Information |
| Other: | ☐ Have | ☐ Don't Have | ☐ Want Information |

## Urinary Incontinence Assessment

| Do you experience leaking in the following situations? | Not at all | A little | Sometimes | A lot |
|---|---|---|---|---|
| During daily activities (work, household task) | ☐ | ☐ | ☐ | ☐ |
| During physical activities (walking, swimming, or other exercise) | ☐ | ☐ | ☐ | ☐ |
| During recreational activities (movies, hobbies) | ☐ | ☐ | ☐ | ☐ |
| During social activities (going out with friends, family visits) | ☐ | ☐ | ☐ | ☐ |
| During car trips | ☐ | ☐ | ☐ | ☐ |
| **In the Past few Weeks:** | | | | |
| Have you frequently experienced the need to urinate? | ☐ | ☐ | ☐ | ☐ |
| Have you experienced leaking before an urgent need to urinate? | ☐ | ☐ | ☐ | ☐ |
| Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity? | ☐ | ☐ | ☐ | ☐ |
| Have you experienced a pressing or immediate urge to urinate? | ☐ | ☐ | ☐ | ☐ |
| Have you noticed a change in your urination frequency? | ☐ | ☐ | ☐ | ☐ |
| Do you need to urinate more than 8 times every 24 hours? | ☐ | ☐ | ☐ | ☐ |
| Do you have to get up more than twice during the night to urinate? | ☐ | ☐ | ☐ | ☐ |
| Do you sometimes have to strain to urinate? | ☐ | ☐ | ☐ | ☐ |

## Fall Risk Screening

| | |
|---|---|
| In the last 12 months have you fallen? | ☐ Yes ☐ No ☐ Unsure |
| If yes, how many times? | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ |
| Were you injured as a result of this fall? | ☐ Yes ☐ No ☐ Unsure |

## Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

| Little interest or pleasure in doing things | Feeling down, depressed, or hopeless |
|---|---|
| ☐ Not at all | ☐ Not at all |
| ☐ Several days | ☐ Several days |
| ☐ More than half the days | ☐ More than half the days |
| ☐ Nearly every day | ☐ Nearly every day |

## Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

| | |
|---|---|
| I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health | 1 2 3 4 5 6 7 8 9 10 |
| I feel that I remember the instructions given to me at my doctor's office when I get home | 1 2 3 4 5 6 7 8 9 10 |
| I feel that I have a strong understanding of medical language | 1 2 3 4 5 6 7 8 9 10 |

Patient Signature:_____ DOB:_____

Print Name:_____ Date:_____

No change in health since previous year_____ (initial) Date:_____

# Waverly Primary Care

## *HIPAA* Disclosure Form

Date: _____

Name_____ Date of Birth_____

**If your address has changed, please provide new address:**

Address_____

City, State, Zip_____

**I authorize Waverly Primary's personnel to leave confidential information about test results, lab reports or billing at the follow number:**

Please provide #_____ ☐ Home ☐ Cell ☐ Work
**(if no number is provided, we will not be able to contact you)**

Email address: _____

**I authorize the persons listed below (**spouse, friend, parents, etc**) to receive healthcare** (incl. picking up Rx's, lab reports, medical records, etc.) **information on my behalf:**

_____

Name Phone Relationship

**Emergency Contact:**
☐ Same as above

_____

Name Phone Relationship

Your Signature_____

# PCMH

## Patient Centered Medical Home

Good communication between patients and physicians is the key to better outcomes. My staff and I are committed to providing you the highest quality medical care. This can best be accomplished by a clear understanding about our responsibilities to you and your rights as a patient in our practice.

Waverly Primary Care

**Our Responsibilities to You:**

| |
|---|
| Respect you as an individual-we will not make judgments based on race, ethnicity, national origin, religion, gender, age, physical disability, sexual orientation or genetic information. |
| Respect your privacy- your medical information will not be shared with anyone else unless you give permission or as required by law |
| Provide the best possible treatment and advice based on current medical evidence- we respect your right to information and will discuss appropriate or medically necessary treatment regardless of cost or benefit coverage. |
| Provide you with timely access to care in our practice, as well as facilitate timely access to specialists, diagnostic services and other care as needed. |

**What We Ask of You:**

| |
|---|
| Ask questions, share your feelings and be a part of your care. |
| Be honest about your history, symptoms and other important information about your health. |
| Tell your doctor about any changes in your health and well-being. |
| Take your medicine as ordered and follow your doctor's advice. If you are unwilling or unable to do so, be honest with the doctor. |
| Make healthy decisions about your daily habits and lifestyle. |
| Prepare for and keep schedule visits or reschedule visits in advance. |
| Call your doctor first with all problems, unless you have a medical emergency. |
| End every visit with a clear understanding of your doctor's expectations, treatment goals and future plans. |

**Please Note**: Our office is open **Moday-Friday 8am-5pm**. When the office is closed we ask that you go to the nearest FastMed Urgent Care facility for non-emergency problems, i.e fever, cold, cough, insect bite. For chest pains, facial weakness, speech slurring etc. go to the emergency room

*By signing below, you indicate that you have read this document and that it is your wish to join our medical home and to do your best to abide by the statements listed above. This is not a legally binding contract, but is inteneded to provide a framework upon which we can build a relationship that will allow you to maximize your health status in a comfortable and welcoming environment.*

Patient Name (Please Print) _____ Patient Signature _____ Date _____

Physician or Representative Signature _____ _____ Date _____