

Patient Name: _____

Patient DOB: _____

REGISTRATION FORM

Date: _____

E-mail address: _____

PATIENT INFORMATION

Patient Name: _____ Age: _____ Sex: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ SSN: _____

() Single () Married () Widowed () Divorce Other: _____

Religion: _____ Affiliation: _____

Referring Physician: _____ Primary Physician: _____

EMPLOYMENT

() Full-time () Part-time () Retired () Self-Employed () Unemployed () Disabled () Minor

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ (Ext: _____)

PERSON RESPONSIBLE FOR BILL

() Same as Patient () Parent/Guardian Other: _____

(if other than patient please fill in the following information)

Name: _____ SSN: _____

Address: _____ Phone Number: _____

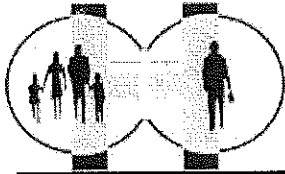
City: _____ State: _____ Zip: _____ Birth Date: _____

() Full-time () Part-time () Retired () Self-Employed () Unemployed () Disabled

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ (Ext: _____)



Patient Name: _____

Patient DOB: _____

EMERGENCY INFORMATION

Next of Kin: _____ **Phone number:** _____

Relationship to patient: () Spouse () Parent/Guardian Other: _____

() Address is same as patient () Different address (please fill in the following information)

Address: _____

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

Person to Notify (Nearest friend or relative): _____

Address: _____

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

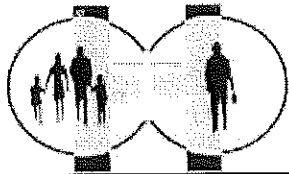
Relationship to patient: _____ **Phone number:** _____

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my provider for this illness or injury, of the provider's benefits otherwise payable to me, but not to exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the provider's office or the party responsible for the billing of these services may check credit with any source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome(AIDS). I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. **I have been notified that I may receive services from the Nurse Practitioner or Physician Assistant at this location.**

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

x _____
Patient or Authorized Person's Signature

x _____
Date/Time



Patient Name:

Patient DOB:

Salina Regional Health Center Contact List/

Authorization to Verbally Release Protected Health Information Contact List:

I authorize Salina Regional Health Center, and all affiliates, health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, caretakers, concerning my health care will not be disclosed without an additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Name of Family Member/Caretaker	Relationship	Phone Number	Allow Messages
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be-disclosed and no longer protected by those regulations.

X _____
Date

X _____
Signature of Patient or Authorized Agent/Representative

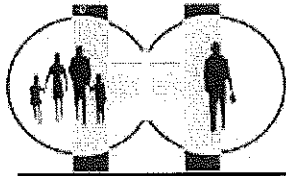
Printed name of authorized agent/representative

Relationship to patient

Address of Authorized agent/representative

Telephone # of authorized agent/representative

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")



Patient Name:

Patient DOB:

TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT

Salina Regional Health Center Physician Clinics, including its acute care rehabilitation unit, emergency departments, outpatient surgery and outpatient departments are herein referred to as "medical group".

1. CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. Further, I understand that among those who attend patients at this medical group are medical, nursing, and other health care personnel in training and volunteer student observers who, unless requested otherwise, may be present during patient care as a part of their education. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by me or my family and the medical group shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the medical group determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

3. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS: I agree that the medical group may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

4. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as a patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the medical group in accordance with its regular rates and terms.

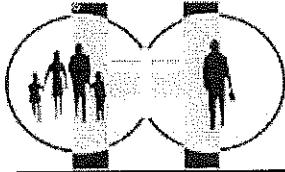
5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the medical group. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable cost of collection, including but not limited to attorney fees and collection agency fees.

6. MEDICARE/MEDICAID/INSURANCE BENEFITS: I authorize the medical group to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the medical group for services furnished me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital.

7. AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES AND WAIVER OF ACCOUNTING:

I understand that as part of its health care operations, the medical group is required by law to disclose certain of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize the hospital to make such disclosures without any accounting of such disclosures since they are required by law.

8. CONTRABAND WEAPONS/DRUGS: I agree that should the medical group find contraband weapons and/or nonprescription drugs not sold over-the-counter with my possession, these items will be confiscated and the police will be contacted.



1100 Highland Drive, Third Floor
Concordia, KS 66901
785-243-4272
FAX 785-243-4275

Patient Name: _____ **Patient DOB:** _____
Patient Phone Number: (785)275-3353

9. TOBACCO PRODUCTS: Salina Regional Health Center is a tobacco free campus. Tobacco use is prohibited on all hospital owned properties including outdoor areas, stairways, parking lots and garages, medical office building properties and entryways. Please send your smoking materials home. If you do smoke, please consider asking your nurse regarding information on smoking cessation programs.

10. PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

11. PATIENT RIGHTS INFORMATION: I have reviewed/received "Patient Right and Responsibilities" and understand my rights as described in that document.

12. NOTICE: Your health information related to work-related illnesses/injuries or to medical surveillance of the work place may be disclosed to your employer.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

X _____
PATIENT/PERSONAL REPRESENTATIVE INITIAL

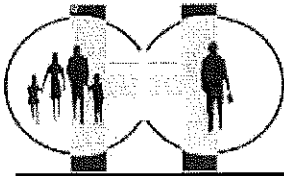
13. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.
I hereby acknowledge that I have received a copy of the medical group's Notice of Privacy Practices.

X _____
PATIENT/PERSONAL REPRESENTATIVE INITIAL

I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

X _____
Patient/Personal Representative Signature Relationship to Patient Date

X _____
Signature, Witness Date



Patient Name: _____

Patient DOB: _____

MEDICAL HISTORY

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

City of Residence: _____ Primary Physician: _____

Chief Complaint: _____ Pharmacy: _____

Medication allergies: (list drug and reaction)

Are you allergic to Intravenous Contrast (iodine dye)? **Yes** **No**

Past Medical History

Previous or current illnesses: (Check all that apply)

- | | | |
|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> GERD | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Coronary Stents | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hernia (What type _____) |
| <input type="checkbox"/> Cancer (What type _____) | | |

Other (Please specify): _____

Anticoagulant Use:

- | | | | | | |
|-------------------------------|---------------------------------|----------------------------------|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Plavix | <input type="checkbox"/> Pradaxa | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Other _____ |
|-------------------------------|---------------------------------|----------------------------------|----------------------------------|-----------------------------------|--------------------------------------|

Previous Surgeries: (type and year)

Last Mammogram: (Date/Year) _____ / _____

Last Colonoscopy: (Date/Year) _____ / _____

Social History

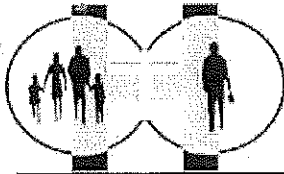
Marital Status _____ Occupation _____

Do you drink alcohol? **Yes** **No** If so, how much per day? _____

Have you ever used street or IV drugs? **Yes** **No**

Do you smoke or use tobacco products? **Yes** **No** If so, how much per day? _____

If you quit, when and how much did you use prior to quitting? _____



Patient Name:

Patient DOB:

Family History: Does anyone in your family have (or have had):

Check all that apply and specify who, what kind, and at what age?

- ___ Heart problems (Please specify): _____
- ___ Blood clotting problems (Please specify): _____
- ___ Cancer (Please specify): _____
- ___ Lung problems (Please specify): _____
- ___ Diabetes: _____
- ___ Bowel disorders (Please specify): _____

System Review: (check all that apply)

- General: ___ Weight gain ___ Recent weight loss ___ Fevers ___ Fatigue ___ Night sweats
- Eyes: ___ Glaucoma ___ Cataracts ___ Wear glasses ___ Sudden loss of vision
- Oropharynx: ___ Dentures ___ Swallowing problems ___ Dental problems
- Cardiac: ___ Chest pain ___ Shortness of breath while sleeping ___ Palpitations ___ Heart Attack
- Respiratory: ___ Short of breath ___ Productive cough ___ Pneumonia ___ Bloody cough ___ Tuberculosis
- ___ Wheezing
- Gastrointestinal: ___ Constipation ___ Abdominal pain (chronic) ___ Blood in stool ___ Diarrhea ___ Hemorrhoids
- Genitourinary: ___ Pain with urination ___ Frequent nighttime urination ___ Urinary incontinence ___ Erectile dysfunction
- ___ Kidney stones
- Musculoskeletal: ___ Muscle weakness ___ Broken bones ___ Arthritis
- Vascular: ___ Swelling ___ Pain in legs with walking ___ Night cramps
- Hematologic: ___ Bleeding problems ___ Blood clots
- Lymphatic: ___ Blood transfusions ___ Swellings in neck/armpits/groins
- Integument: ___ Skin cancers ___ Chronic rashes ___ Reaction to tape
- Psychiatric: ___ Depression ___ Mental illness requiring hospitalization
- Neurologic: ___ Seizures ___ Balance problems ___ Dizziness ___ Strokes ___ TIA's
- Endocrine: ___ Heat intolerance ___ Cold intolerance
- Breasts: ___ Itchy ___ Scaliness of the nipple ___ Swelling ___ Pain ___ Nipple discharge

For Nursing Use:

HT _____ Weight _____ BP _____ / _____ Pulse _____ Respirations _____

