BLOSSOMWOOD MEDICAL
WALK IN CLINIC
PRIMARY CARE FOR ADULTS

2121 Whitesburg Drive, Suite C
Huntsville, AL 35801
BlossomwoodMedical.com
Phone: (256) 883-0107
Fax: (256) 883-0207

New Patient Registration

Name: _____ DOB: _____ Sex: ____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Secondary Phone: _____

SSN: _____ Preferred Language: _____ Race: _____

Employer: _____ Occupation: _____ Work Phone: _____

Employer Address: _____

Marital Status (please circle one): M S D W

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Occupation: _____ Spouse's Work Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Last Primary Care Physician?: _____ How did you hear about us?: _____

PRIMARY INSURANCE INFORMATION:

Cardholder Name: _____ Patient Name: _____

Relation to Patient: _____ Sex: _____ Cardholder's DOB: _____ Co-pay: _____

Member ID#: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Cardholder Name: _____ Patient Name: _____

Relation to Patient: _____ Sex: _____ Cardholder's DOB: _____ Co-pay: _____

Member ID#: _____ Group #: _____

If Blossomwood Medical is a provider for your insurance company, the guarantor or responsible party for the patient's account will be required to pay all co-pays and/or deductibles as outlined in their insurance policy. For all other insurance companies, guarantor or responsible party will be 100% responsible for charges incurred for all services rendered according to Blossomwood Medical's fee schedule.

I hereby authorize payment of medical benefits directly to physician of benefits due me or my dependents for services rendered. I further authorize the physician to release any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance. Should any account become delinquent, I will be responsible for any collection, attorney, court, or other fees.

_____ _____

Signature **Date**

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Authorization for Release/Request of Protected Health Information (PHI)

Please fill out this form if you would like to transfer records to or from Blossomwood Medical.

Patient's Name: _____ DOB: _____
Address: _____
City/Town: _____ State: _____ Zip Code: _____
SSN: _____ Patient's Phone Number: _____
Date of Request: _____ Date Information Needed: _____

☐ **I authorize Blossomwood Medical to:**

RELEASE information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone & Fax Number

OR

☐ **I authorize Blossomwood Medical to:**

RECIEVE information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone & Fax Number

Reason for this request:

☐ Health Care ☐ Insurance ☐ Personal ☐ Other

Type of Records Requested:

☐ Lab Results ☐ Imaging Results ☐ Office Note ☐ Other

☐ Records relating to a specific date: _____ ☐ All medical records

- **I understand that my right to healthcare treatment is not conditioned on this authorization.**
- **I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where disclosure has already been made in reliance.**
- **Release of HIV related information, mental health related care, or substance abuse diagnoses and treatment requires addition authorization.**

_____ _____
Signature **Date**

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Privacy Practices; Consent for Use; Disclosure of Protected Health Information (PHI)

I, _____, was provided with a copy of Blossomwood Medical's Privacy Practices Notification. Blossomwood Medical may revise its notification at any time. I understand that this copy is always available upon request. By signing this document, I acknowledge that I have read, understand, and agree to the terms of the consent. Further, I hereby consent and authorize Blossomwood Medical to use or disclose my PHI in conjunction with Blossomwood Medical's treatment, payment, or healthcare operations in accordance with the terms of this consent.

_____ _____

Signature **Date**

I hereby authorize and give my consent to Blossomwood Medical to leave messages on my answering machine/voicemail for the following **(check all that apply)**:

- ☐ Appointment Reminders
- ☐ Medical Information
- ☐ Insurance/Payment Concerns
- ☐ Prescription Refills
- ☐ Test/Lab Results
- ☐ Mail

Furthermore, I authorize and give consent to Blossomwood Medical to communicate any of my PHI to the following person(s):

Name	Relation	Phone Number
Name	Relation	Phone Number
Name	Relation	Phone Number
Name	Relation	Phone Number

_____ _____

Signature **Date**

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Medication List

Name: _____ DOB: _____

Male or Female? (circle one): M F Phone Number: _____

Pharmacy Name	Pharmacy Phone	Pharmacy Address

Allergies	Reaction (please describe: rash, itching, swelling)

Medication	Dosage	How often? How?	Reason for Taking	Date Started/Date Ended	Prescriber
Ex: Benadryl	40mg	Twice, by mouth	Allergies	7/1/2014 - Current	Pukis

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Health History Part II

Family History (Fill in as much as you can.)

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if any BLOOD relative have ever had the following (check all that apply, and specify whom).

- ☐ Asthma: _____
- ☐ Gout: _____
- ☐ Arthritis: _____
- ☐ Hay Fever: _____
- ☐ Cancer: _____
- ☐ Chemical Dependence: _____
- ☐ Diabetes: _____
- ☐ Heart Disease: _____
- ☐ Strokes: _____
- ☐ Hypertension: _____
- ☐ Kidney Disease: _____
- ☐ Tuberculosis: _____
- ☐ Thyroid Disease: _____
- ☐ Other: _____

Personal Medical History (Circle 'Y' for yes or 'N' for no.)

1. Do you regard your work as stressful? Y N
2. Do you regard your homelife as tense? Y N
3. Are you a perfectionist? Y N
4. Do you have trouble sleeping? Y N
5. Do you "blow up" often? Y N
6. Do you become depressed easily? Y N
7. Are you frequently irritable? Y N
8. Have you ever had a blood transfusion? Y N
   If yes, when? _____
9. Do you exercise at all? Y N
   If yes, how often? _____
   What kind? _____
10. Have you ever been treated by a pain management physician? Y N
    If yes, whom? _____

Surgeries (Please list what kind, date, and surgeon.)

What?	When?	By Whom?

Occupational Concerns (Check all that your work exposes you to.)

- ☐ Stress
- ☐ Hazardous Substances
- ☐ Heavy Lifting
- ☐ Other

Please specify:

_____

_____

What is your occupation?

_____

Heath Habits (Please check all that apply. Note how much you use, and the approximate beginning date of each substance.)

- ☐ Caffeine
  How much? _____
  Begin date: _____
- ☐ Tobacco
  How much? _____
  Begin Date: _____
- ☐ Alcohol
  How much? _____
  Begin date? _____
- ☐ Other: (please specify) _____
  How much? _____
  Begin date: _____

I certify that the above information is correct to the best of my knowledge. I will not hold any member of the Blossomwood Medical staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature **Date**

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Health History

Name: _____ DOB: _____ Age: _____

Date of Last Physical: _____ Reason for Visit: _____

Symptoms (check symptoms you currently have or have had in the past 12 months)

General:
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone:
(Pain, weakness, numbness)
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hants
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Skin:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Gastroenterology:
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular:
- ☐ Chest pain
- ☐ Hypertension
- ☐ Hypotension
- ☐ Murmur
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Urinary:
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Incomplete emptying of bladder

Eye, Ear, Nose, Throat:
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

MEN Only:
- ☐ Breast lump
- ☐ Erection difficulty
- ☐ Testicular lump
- ☐ Penile discharge
- ☐ Sore on penis
- ☐ Other:

_____

Date of last prostate exam:
_____

WOMEN Only:
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Severe menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other:

_____

Date of last menstruation:
_____

Date of last pap smear:
_____

Have you ever had a mammogram:
_____

Are you pregnant?
_____

Number of children:
_____

Conditions (check conditions you have or have had in the past twelve months)

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV+
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease