BOOTHBAY REGION Health Center

185 Townsend Ave Suite R • Boothbay Harbor, ME 04538 • *(207) 633-1075*

Fit, Flexible, & Strong **Wellness Program Check List**

Participant REGISTRATION & Checklist

NAME:________________________________ DOB: ____/____/____
AGE:_______

BEST PHONE NUMBER:________________________________

E-MAIL ADDRESS:____

MAILING ADDRESS:____

EMERGENCY CONTACT NAME:___________________________

EMERGENCY CONTACT PHONE:_________________/ RELATIONSHIP_________

PRIMARY CARE PHYSICIAN'S NAME :___________________________________/
PHONE:________________

Need transportation help? □ Yes □ No

Information to be filled out by Health Center Staff.

□ Privacy Practices Statement given Date_________

□ Patient consent, release, and assignment of benefits Date______

□ Release to request Personal Health Information (From PCP) signed Date_______

PATIENT CONSENT, RELEASE, AND ASSIGNMENT OF BENEFITS

I. CONSENT TO TREAT

I hereby consent to and authorize Boothbay Region Health Center (BRHC), its physicians, residents, interns, employees, students, and other individuals involved in this care to administer such diagnostic procedures or treatment or both as may be advisable to evaluate and treat my injury or illness. I understand that the physician or surgeon responsible for my care has the responsibility to explain to me the purpose of, benefits of and the usual and most frequent risks and-hazards involved in the diagnosis and treatment of any illness or injury as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I also understand that I may execute an Advance Directive. (Or I have been asked if I have an advanced directive and was offered information about executing one.)

II. RELEASE OF INFORMATION

I understand that information concerning my treatment and condition is available to those involved in my care and in the organization's quality improvement plan. I authorize BRHC to release and discuss records containing my health care information to other health care institutions, organizations or facilities as necessary to continue my care or treatment at the direction of my practitioner.

I also authorize BRHC to disclose my health care information to my insurance carrier(s) or other third parties paying for this care, as well as their contracted review organizations, to the extent reasonably necessary to allow them to pay for my treatment. This authorization will expire after treatment and payment has occurred, or one year (12 months). I understand that I may revoke this authorization at any time should I desire by notifying BRHC in writing, subject to the rights of anyone who acted in reliance on this authorization prior to receiving notice of the revocation.

I further understand that I may review my records and refuse authorization to disclose all or some of the information contained therein, but that refusal may result in improper diagnosis or treatment, denial of coverage of a claim for health benefits or other insurance or other adverse consequences.

If I have been diagnosed or treated for any of the following, I understand BRHC needs my specific consent to disclose related information. I may cross out any of the following that do not apply:

[ ] I (DO / DO NOT) authorize disclosure of information which refers to treatment or diagnosis **of DRUG OR ALCOHOL ABUSE.** Such information may not be re-disclosed by the recipient without my specific written consent.

[ ] I (DO / DO NOT) authorize disclosure of information which refers to treatment or diagnosis of **MENTAL HEALTH.**

[ ] I (DO / DO NOT) wish to review such information prior to its release. Review must be supervised and a separate release of records signed.)

I understand that I am entitled to a copy of this authorization form. I further understand that my physician(s) will be provided with a copy of this authorization for billing purposes.

WITNESS	PATIENT OR AUTHORIZED REPRESENTATIVE	DATE

III. PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I understand that I am responsible for payment of all charges associated with this treatment. I further understand that I am financially responsible in the event that payment is denied or rejected by my health insurance carrier(s) or third parties and for those charges not covered by the policy benefits as deductible and co-insurance or otherwise not covered by this assignment. I hereby assign to BRHC a sufficient amount of all money to which I may be or become entitled to as a result of this treatment and further authorize payment from my health insurance carrier(s) or other financially responsible third parties directly to BRHC to the extent necessary to pay for this treatment.

WITNESS	PATIENT OR AUTHORIZED REPRESENTATIVE	DATE

M

Name: ______________________ **Date of Birth:** ______________ **Date:** ______________

Medication List - Please include over-the-counter medication, vitamins, etc.

Medication Name	Strength in mg	How often? (i.e. 3 times a day, 2 at bedtime, etc.	Medication Name	Strength in mg	How often? (i.e. 3 times a day, 2 at bedtime, etc.

Drug Allergies

Drug	Reaction	Drug	Reaction

Name:______________________ Date of Birth: ____________ Date: ______________

PAST MEDICAL HISTORY

Ear/Nose/Throat
- ☐ Tonsillitis
- ☐ Ear infections
- ☐ Sinus infections
- ☐ Dental problems
- ☐ Hearing loss
- ☐ Sleep apnea
- ☐ Use oxygen

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia

Allergic
- ☐ Seasonal allergies
- ☐ Environmental allergies

Cardiac
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Pacemaker/defibrillator
- ☐ Atrial fibrillation
- ☐ Blood clot (DVT)
- ☐ High cholesterol
- ☐ High blood pressure

Gastrointestinal
- ☐ Ulcers
- ☐ Liver disease
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Hepatitis
- ☐ Diverticulitis
- ☐ Hemorrhoids

Genitourinary
- ☐ Prostate Problem
- ☐ Kidney stones
- ☐ Kidney disease

Breasts
- ☐ Breast lump
- ☐ Fibrocystic disease

Endocrine
- ☐ Diabetes
- ☐ Goiter
- ☐ Thyroid Problems
- ☐ Osteoporosis/osteopenia

Infectious Diseases
- ☐ Chicken pox
- ☐ Gonorrhea
- ☐ Herpes
- ☐ AIDS/HIV positive
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Venereal disease
- ☐ Shingles

Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Strabismus (lazy eye)

Hematology/Lymph
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Bruise easily
- ☐ Swollen glands
- ☐ Blood transfusions
- ☐ Blood type__________

Skin
- ☐ Extensive sun exposure
- ☐ Eczema

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ Back trouble
- ☐ Scoliosis
- ☐ Carpal tunnel
- ☐ Sciatica
- ☐ Fracture

Neurology
- ☐ Epilepsy/seizures
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Stroke

Mental
- ☐ Alcoholism
- ☐ Anorexia
- ☐ Bulimia
- ☐ Chemical dependency
- ☐ Psychiatric Care
- ☐ Suicide Attempt

Cancer

Type/location/treatment

____

____

____

____

____

____

____

Other Conditions
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

SURGICAL HISTORY

Date	Operation

SERIOUS ILLNESSES, INJURIES, HOSPITALIZATIONS

Date	Description

Please complete other side! Thank you