



Morehead Primary Care

Ad Majorem Dei Gloriam

PATIENT REGISTRATION

Please fill out form completely. The following information will help us in providing you with the best medical care and treatment possible. If you have any questions, please contact the office. Thank you and we look forward to seeing you!

PATIENT INFORMATION

First name _____ Middle Initial _____ Last Name _____

Date of Birth ___/___/___ SSN _____ Gender: (circle one) Male or Female

Home Address _____ City _____ State _____ Zip Code _____

Mailing Address _____ City _____ State _____ Zip Code _____

Check box if homeless

Home Phone: _____ Cell Phone: _____

Email Address _____

Employed: (circle one) YES or NO

Retired: (circle one) YES or NO

Disabled: (circle one) YES or NO

If yes: Employer Name: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____

School (for ages 6 years to 18 years old)

Name of School _____ Grade _____

ADDITIONAL INFORMATION

Race (circle one)

American Indian or Alaska Native

Hispanic

Asian

Native Hawaiian or Pacific Islander

African American

White

Other _____

Staff Initials: _____

Ethnicity (circle one)

Hispanic or Latino

Not Hispanic or Latino

Marital Status (circle one): Married, Single, Widowed, Divorced, Separated, Never Married

Preferred Language _____

Emergency Contact Name _____ Emergency Contact Number _____

Who is your Primary Care Provider (PCP)? (circle one)

Christian Weigel, MD

Nancy Weigel, MD

Jeremy Keller, DO

Ali Percy, PA

Denise Gore, NP

Monica Taylor, NP

Amber Ball, PA

INSURANCE INFORMATION

Primary Insurance Company Name _____

Policy ID _____

Group ID _____

Policy Holder's Name _____

Policy Holder Date of Birth ____/____/____

Policy Holder's Address if different from patient: _____

Policy Holder SSN _____ - _____ - _____

Patient Relationship to Policy Holder (circle one)

Self

Dependent/Child

Spouse

Secondary Insurance Name _____

Policy ID _____

Group ID _____

Policy Holder Name _____

Policy Holder Date of Birth ____/____/____

Policy Holder SSN _____ - _____ - _____

Patient Relationship to Policy Holder (circle one)

Self

Dependent/Child

Spouse

Staff Initials: _____

FINANCIAL RESPONSIBILITY (person responsible for bill)

First Name: _____ Last Name: _____

Address: _____ City _____ State: _____ Zip: _____

Relationship to the patient (circle one): Spouse, Parent, Guardian, Other _____

Authorization for Release of Medical Information to other individuals:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Miscellaneous Information

Do you have a **Power of Attorney or Health Care Proxy/Surrogate?** Yes No

(An "agent" designated by the patient, the patient's family, or by the courts to make health decision for him or her in the event that the patient is unable to do so.)

If YES, please submit appropriate documents to front desk staff.

Do you have a **Living Will or Advance Directives?** Yes No

(Documents which give the patient a voice in decisions about their medical care when he/she is unconscious or too ill to communicate.)

If YES, please submit to front desk staff to be copied

If NO, and you would like additional information, please ask front desk for information packet.

Staff Initials: _____

MEDICAL HISTORY

Please list all medications you are currently taking (including over the counter meds)

Please list any allergies and reactions

Please circle all that apply:

- Heart Disease
- Diabetes
- Asthma
- Hypothyroidism
- High Blood Pressure
- Seizure
- Depression
- Cancer
- High Cholesterol
- Mental
- Stroke
- None

Type of Cancer (If applicable): _____

SOCIAL HISTORY

Do you smoke? (circle one) No Yes Occasionally: How many cigarettes per day? _____

Do you drink alcohol? (circle one) No Yes Occasionally: How often? _____

Staff Initials: _____

FAMILY HISTORY

Does anyone in your family (living or deceased) have the following? (circle)

- High Blood Pressure
- Stroke
- Depression
- High Cholesterol
- Heart Disease
- Mental Illness
- Cancer
- Diabetes
- Hypothyroidism

Other _____

SURGICAL HISTORY

Please circle all that apply:

- Appendix
- Gallbladder
- Tonsils/Adenoids
- C-Sections
- Hysterectomy
- Heart

Other _____

***For Office Use Only:**

The following in Demographics need to be filled out: Language, Race, Ethnicity. Initial when completed _____
On Amazing Charts Side check the create portal box, initial when completed _____
On Amazing Charts Side, preferred provider entered, initial when completed _____
On ACPM side, preferred provider entered two places, initial when completed _____

Staff Initials: _____



HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services. This authorization remains valid until it is revoked by the patient or Morehead Primary Care.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose as needed your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your physician is not required to agree to a restriction that you may request. If physician or provider believes it is in your best interest to permit use and disclosure of your protected health information. You then have a right to use another Healthcare Professional.

Signature: _____ Print Name: _____ Date: _____

Date of birth: _____

Staff Initials: _____