ISU Meridian Healthcare
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1734 / Fax: 833.390.1293

Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
Family Physician or Pediatrician:	Date of Birth:		Sex: ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Signature of Responsible Party: **X** _____ **Date:** _____

Printed Name of Responsible Party: **X** _____ **Date:** _____

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PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type:_____Amount/day:_____Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

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Consent for Treatment / Statement of Financial Responsibility

Consent for Treatment

I consent to the use or disclosure of my protected health information by the ISU Meridian Healthcare staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes.

ISU Meridian Healthcare is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The "Notice of Privacy Practices describes my rights as well as ISU's rights and responsibilities with respect to my protected health information.

Billing Policy

We are happy to bill your private insurance as long as you provide us with a copy of your insurance card front and back. In cases where we cannot direct bill your insurance, we will provide you with a copy of your charges to send in to your insurance company. By signing this form you agree to the following authorizations and policies.

- I authorize release of any protected health information to my insurance company necessary to process an insurance claim.
- I authorize ISU Meridian Healthcare to act as my agent in helping me to obtain payment from my insurance company.
- I authorize payment to be made directly to my doctor/clinic.
- I understand that I am responsible for any legal or collection fees if my account is turned over to collections for non-payment.

The Health Center and its staff cannot guarantee insurance payments or benefits for any insurance company.

If your insurance company denies the claim or pays only a portion of it, you are responsible for the balance. A monthly statement will be sent to you. Be sure we have your correct address and phone number on file. We are happy to assist you with a payment plan if needed. Just let us know how we can help.

If your insurance company denies the claim or pays only a portion of it, you are responsible for the balance.

Photography/Other Images

I understand that my photographs, videotapes, digital or other images may be used to assist with diagnosis and treatment.

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Email/Text Reminders

I authorize ISU Meridian Healthcare to send appointment reminders via:

☐ Text ☐ Email: _____

☐ No reminders via text or email.

I have read and understand the content of this form.

_____ _____
Print Name of Patient or Personal Representative *Date*

_____
Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Idaho State University

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Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Meridian Healthcare Notice of Privacy Practices.

_____ _____

Print Name of Patient or Personal Representative *Date*

_____

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

1. Does the patient have a copy of the Notice of Private Practices? ☐ Yes ☐ No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:

   ☐ Patient/individual refused to sign _____ (Date of Refusal).
   ☐ Communication barriers prohibited obtaining an acknowledgement.
   ☐ Legal representative not available.
   ☐ Patient bypassed registration.
   ☐ An emergency situation prevented ISU from obtaining an acknowledgement.
   ☐ Other: _____
   _____

Completed By: _____ _____
Signature Date