physicians
Immediate Care & Medical Centers
Where your good health always comes first

PATIENT REGISTRATION

PATIENT INFORMATION

Social Security # ____

First Name________________________________ Middle __________

Last Name ____

Home Address ____

City ___________________________ State _____ Zip ____________

☐ Male ☐ Female Date of Birth _____ /_____ /________

Race: ☐ Black ☐ White ☐ Asian ☐ Hawaiian ☐ American Indian

Ethnicity: ☐ Latino/Hispanic ☐ Not Latino/Hispanic

Preferred Language: ☐ English ☐ Other Language

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Phone (______)_____________________ ☐ Home ☐ Work ☐ Cell

2nd Phone (______)___________________☐ Home ☐ Work ☐ Cell

Email Address ______________________________________

Employer____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARDS TO THE RECEPTIONIST

Insurance Company ____

Insured/Card Holder's Name ____ Date of Birth ____ /____ /________

Relationship to patient ____________________________________ Employer's Name ____

SECONDARY INSURANCE INFORMATION

Insurance Company ____

Insured/Card Holder's Name ____ Date of Birth ____ /____ /________

Relationship to patient ____________________________________ Employer's Name ____

EMERGENCY CONTACT

First Name________________________________ Middle _______

Last Name ____

Relationship ____

Primary Phone (______)____________________________________

GUARANTOR/RESPONSIBLE PARTY

Social Security OR Driver's License #___________________________

Relationship ____

First Name__________________________________ Middle _______

Last Name ____

Address ____

City ___________________________ State ____ Zip ____________

☐ Male ☐ Female Date of Birth _____ /_____ /________

Primary Phone (_____)___________________________________

SIGNATURE BLOCK

I understand that medical treatment will be performed by licensed health care professionals and their staff. I hereby give my **consent for treatment** and affirm that no guarantee has been made as to the results of such treatment. I authorize PHYSICIANS to **release to my insurance carrier** any information necessary to process insurance claims on my behalf. I authorize my insurance carrier to make payments for medical benefits received directly to PHYSICIANS. I acknowledge that **I have received, read, and understood** a copy of PHYSICIANS Financial Information Sheet. **I agree to accept full financial responsibility** for that part of my health care expense, including co-payments, for which my insurance will not pay.

Signature ____ Date ____________________________

New Patient History Information

Name:______________________________ Date________________

Surgical History, if yes, please note year done.

Adenoidectomy: [Y] [N] _______________

Tonsillectomy: [Y] [N] _______________

Sinus Surgery: [Y] [N] _______________

Heart Surgery: [Y] [N] _______________

Lung Surgery: [Y] [N] _______________

Breast Biopsy: [Y] [N] _______________[R] [L]

Back Surgery: [Y] [N] _______________

Appendectomy: [Y] [N] _______________

Gallbladder Removal: [Y] [N] _______________

LAP (or other Gastric Surgery): [Y] [N] ________

Bladder Surgery: [Y] [N] _______________

Colon Surgery: [Y] [N] _______________

Inguinal Hernia Repair: [Y] [N] _____________

Hip Replacement: [Y] [N] _____________[R] [L]

Knee Surgery: [Y] [N] _______________ [R] [L]

Female Surgical History

Vaginal Hysterectomy: [Y] [N] _____________

Total Abdominal Hysterectomy: [Y] [N] _____

Lumpectomy: [Y] [N] _______________[R] [L]

Needle Aspiration: [Y] [N] ___________[R] [L]

Excisional Breast Biopsy: [Y] [N] _______[R] [L]

Female Procecures/Tests

Last Mammogram Date:________________

Cervical Pap Smear: ________________

Abnormal Pap Smear: ________________

Last Tetanus Immunization: _______________

Last time Labs (blood) were drawn: __________

What Lab did you use: Tri City Lab/Interpath Lab

Male Surgical History

Prostate Surgery:[Y] [N] _______________

Testis Reduction of Torsion of Testes: [Y] [N] _________

Ventricular Assist Device: [Y] [N] _______________

Procedure/Tests (please note the year)

EKG__________

Treadmill Test__________

Chest X-Ray __________

Breathing Function Test__________

Colonoscopy __________

Bone Density Studies (DEXA Scan)__________

Social Status (please circle the most appropriate answer)

Working: Full Time Part Time Unemployed Retired

Educational Level: High School Some College Degree

Currently in School: [Y] [N]

Marital Status: Married Single Separated Divorced Widowed

Children: [Y][N] if yes: Name and Year of birth

____

____

Family Status::

(if deceased please note age & cause of death)

Father: _______________________________________

Mother: _______________________________________

Maternal (Mom's side) Grandmother:_______________

Maternal Grandfather: ____________________________

Paternal (Dad's side) Grandmother:_______________

Paternal Grandfather: ____________________________

Habits:

Smoking

[ ] Never a Smoker

Cigarettes: [Y] [N] Packs per day: ______

Cigars [Y] [N] # Per day: __________

Chewing Tobacco: [Y] [N] # Cans per week____

Former Smoker: [Y] [N] How many years:_______

Exposure to second hand smoke: [Y] [N]

Using Vapor or E-Cig [Y] [N]

Caffeine:

Coffee [Y] [N] Cups per day:_________

Tea [Y] [N] Cups per day:_________

Cola [Y] [N] Cans per day:_________

Alcohol:

[ ] No Alcohol Use

Beer: [Y] [N] Cans/bottles per day:_________

Wine: [Y] [N] Glasses per day:_________

Hard Liquor: [Y] [N] Drinks per day:_________

Recovering Alcoholic: [Y] [N]

Drug use: [Y] [N] Type:________________

Exercise Habits:

[ ] Regular weight-bearing exercise

[ ] Moderate exercising LESS than 3 times a week

[ ] Moderate exercising 3 or MORE times a week

[ ] Strenuous exercising LESS than 3 times a week

[ ] Strenuous exercising 3 or MORE times a week

[ ] Athletic conditioning

[ ] Being Sedentary

Current Medications:

Medication Name and Strength	Dose	Prescriber

Medication Allergies:

Medication	Reaction

Personal Medical History

Pleas indicate which, if any, you have/had:

Skin Disorder:

Eczema: [Y] [N]

Acne: [Y] [N]

Psoriasis: [Y] [N]

Rosacea: [Y] [N]

Respiratory:

Asthma: [Y] [N]

Emphysema: [Y] [N]

Cardiovascular:

Hypertension (high blood pressure): [Y] [N]

High Cholesterol: [Y] [N]

Heart Disease: [Y] [N]

Heart Attack: [Y] [N]

Heart Failure: [Y] [N]

Gastrointestinal:

Gallstones: [Y] [N]

Irritable Bowel: [Y] [N]

Refulx (heartburn): [Y] [N]

Liver Disorder: [Y] [N]

Hemorrhoids: [Y] [N]

Allergies:

Seasonal: [Y] [N]

Foods: [Y] [N]

Other: [Y] [N]

Renal:

Kidney Cysts: [Y] [N]

Kidney Stones: [Y] [N]

Rheumatologic:

Osteoarthritis: [Y] [N]

Rheumatoid Arthritis: [Y] [N]

Lupus: [Y] [N]

Fibromyalgia: [Y] [N]

Endocrine:

Diabetes (Childhood): [Y] [N]

Diabetes (Adult): [Y] [N]

Hyperthyroidism: [Y] [N]

Hypothyroidism: [Y] [N]

Hematology:

Anemia: [Y] [N]

Clotting disorder: [Y] [N]

Personal Medical History

Pleas indicate which, if any, you have/had:

Cancer:

Breast Cancer: [Y] [N]

Leukemia: [Y] [N]

Lung Cancer: [Y] [N]

Colon Cancer: [Y] [N]

Thyroid Cancer: [Y] [N]

Non-Hodgkin's Lymphoma: [Y] [N]

Malignant Lymphoma: [Y] [N]

Melanoma: [Y] [N]

Other Skin Cancer: [Y] [N]

Neurology:

Headaches: [Y] [N]

Seizures: [Y] [N]

Alzheimer's: [Y] [N]

Multiple Sclerosis: [Y] [N]

Stroke Syndrome: [Y] [N]

Psychiatric:

Attention Deficit Disorder (ADD): [Y] [N]

Attention Deficit Disorder w/Hyperactivity: [Y] [N]

Depression: [Y] [N]

Anxiety: [Y] [N]

Alcohol Dependence: [Y] [N]

Male History:

Testicular Cancer: [Y] [N]

Testicle Pain: [Y] [N]

Erectile Disorder: [Y] [N]

Male Infertility: [Y] [N]

Prostate Cancer: [Y] [N]

Enlarged Prostate: [Y] [N]

Prostatitis: [Y] [N]

Female History:

Cervical Cancer: [Y] [N]

Pelvic Pain: [Y] [N]

Ovarian Cysts: [Y] [N]

Female Infertility: [Y] [N]

Decreased Sexual Urge: [Y] [N]

Stress Incontinence: [Y] [N]

Menopause: [Y] [N] What year did symptoms begin_____

Absence of or light bleeding during periods: [Y] [N]

Bleeding between periods: [Y] [N]

Excessive bleeding during periods: [Y] [N]

Breast Cysts: [Y] [N]

Family Medical History

Please indicate which, if any, of your family members

have or had any of the following to the best of you knowledge:

	Mother	Father	Sister	Brother
Skin Disorder:				
Eczema	[ ]	[ ]	[ ]	[ ]
Psoriasis	[ ]	[ ]	[ ]	[ ]
Allergies:				
Seasonal	[ ]	[ ]	[ ]	[ ]
Food	[ ]	[ ]	[ ]	[ ]
Respiratory:				
Asthma	[ ]	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	[ ]
Cardiovascular				
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
High Cholesterol	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]
Heart Attack	[ ]	[ ]	[ ]	[ ]
Heart Failure	[ ]	[ ]	[ ]	[ ]
Gastrointestinal				
Gallstones	[ ]	[ ]	[ ]	[ ]
Irritable Bowel	[ ]	[ ]	[ ]	[ ]
Reflux	[ ]	[ ]	[ ]	[ ]
Renal Disorders				
Kidney Cysts	[ ]	[ ]	[ ]	[ ]
Kidney Stones	[ ]	[ ]	[ ]	[ ]
Rheumatology				
Osteoarthritis	[ ]	[ ]	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]	[ ]	[ ]
Lupus	[ ]	[ ]	[ ]	[ ]
Fibromyalgia	[ ]	[ ]	[ ]	[ ]

I have no knowledge of my family history: [ ]

Family Medical History

Please indicate which, if any, of your family members

have or had any of the following to the best of you knowledge:

	Mother	Father	Sister	Brother
Endocrine:				
Diabetes (Childhood)	[ ]	[ ]	[ ]	[ ]
Diabetes (Adult)	[ ]	[ ]	[ ]	[ ]
Hyperthyroidism	[ ]	[ ]	[ ]	[ ]
Hypothyroidism	[ ]	[ ]	[ ]	[ ]
Hematology:				
Anemia	[ ]	[ ]	[ ]	[ ]
Cancer				
Breast Cancer	[ ]		[ ]	
Leukemia	[ ]	[ ]	[ ]	[ ]
Prostate Cancer		[ ]		[ ]
Lung Cancer	[ ]	[ ]	[ ]	[ ]
Colon Cancer	[ ]	[ ]	[ ]	[ ]
Thyroid Cancer	[ ]	[ ]	[ ]	[ ]
Malignant Lymphoma	[ ]	[ ]	[ ]	[ ]
Melanoma	[ ]	[ ]	[ ]	[ ]
Other Skin Cancers	[ ]	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]	[ ]
Neurology				
Headaches	[ ]	[ ]	[ ]	[ ]
Epilepsy	[ ]	[ ]	[ ]	[ ]
Alzheimer's	[ ]	[ ]	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]
Psychiatric				
ADD/ADHD	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]
Anxiety	[ ]	[ ]	[ ]	[ ]
Bipolar	[ ]	[ ]	[ ]	[ ]
Alcohol Addiction	[ ]	[ ]	[ ]	[ ]

Family Medical History

Please indicate which, if any, of your Grandparents have or had any of the following to the best of you knowledge:

	Maternal (mom's side) Grandmother	Maternal (mom's side) Grandfather	Paternal (dad's side) Grandmother	Paternal (dad's side) Grandfather
Skin Disorder:				
Eczema	[ ]	[ ]	[ ]	[ ]
Psoriasis	[ ]	[ ]	[ ]	[ ]
Allergies:				
Seasonal	[ ]	[ ]	[ ]	[ ]
Food	[ ]	[ ]	[ ]	[ ]
Respiratory:				
Asthma	[ ]	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	[ ]
Cardiovascular				
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
High Cholesterol	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]
Heart Attack	[ ]	[ ]	[ ]	[ ]
Heart Failure	[ ]	[ ]	[ ]	[ ]
Gastrointestinal				
Gallstones	[ ]	[ ]	[ ]	[ ]
Irritable Bowel	[ ]	[ ]	[ ]	[ ]
Reflux	[ ]	[ ]	[ ]	[ ]
Renal Disorders				
Kidney Cysts	[ ]	[ ]	[ ]	[ ]
Kidney Stones	[ ]	[ ]	[ ]	[ ]
Rheumatology				
Osteoarthritis	[ ]	[ ]	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]	[ ]	[ ]
Lupus	[ ]	[ ]	[ ]	[ ]
Fibromyalgia	[ ]	[ ]	[ ]	[ ]

Family Medical History

Please indicate which, if any, of your Grandparents have or had any of the following to the best of you knowledge:

	Maternal (mom's side) Grandmother	Maternal (mom's side) Grandfather	Paternal (dad's side) Grandmother	Paternal (dad's side) Grandfather
Endocrine:				
Diabetes (Childhood)	[ ]	[ ]	[ ]	[ ]
Diabetes (Adult)	[ ]	[ ]	[ ]	[ ]
Hyperthyroidism	[ ]	[ ]	[ ]	[ ]
Hypothyroidism	[ ]	[ ]	[ ]	[ ]
Hematology:				
Anemia	[ ]	[ ]	[ ]	[ ]
Cancer				
Breast Cancer	[ ]		[ ]	
Leukemia	[ ]	[ ]	[ ]	[ ]
Prostate Cancer		[ ]		[ ]
Lung Cancer	[ ]	[ ]	[ ]	[ ]
Colon Cancer	[ ]	[ ]	[ ]	[ ]
Thyroid Cancer	[ ]	[ ]	[ ]	[ ]
Malignant Lymphoma	[ ]	[ ]	[ ]	[ ]
Melanoma	[ ]	[ ]	[ ]	[ ]
Other Skin Cancers	[ ]	[ ]	[ ]	[ ]
	[ ]	[ ]	[ ]	[ ]
Neurology				
Headaches	[ ]	[ ]	[ ]	[ ]
Epilepsy	[ ]	[ ]	[ ]	[ ]
Alzheimer's	[ ]	[ ]	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]
Psychiatric				
ADD/ADHD	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]
Anxiety	[ ]	[ ]	[ ]	[ ]
Bipolar	[ ]	[ ]	[ ]	[ ]
Alcohol Addiction	[ ]	[ ]	[ ]	[ ]

NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the PICMC Privacy Officer at 310 Torbett Street, Richland, WA 99352.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legally authorized individual	Date Time
Printed Name of person signing	Patient Date of Birth
Printed name of patient if signed on behalf of the patient	Relationship to patient (parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

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"No Show" and Late Cancellation Policy

We at Physicians realize our patients lead very busy lives and will occasionally forget their appointments or have a conflict. For this reason, we call 2 days before appointments to confirm or change them as necessary. When a patient does not show up for an appointment, the opportunity to fill that appointment time is lost, but the associated expenses are not. A No Show fee will be assessed for a missed appointment or when it has not been canceled or rescheduled within 24 hours of the appointment. For your convenience you have the ability to cancel your appointment through our automated call confirm service.

If you miss your appointment or do not cancel with the required notice, these fees will be applied:

Office Visit:	$50.00	
Nerve Conduction Studies	$75.00	Dr. Conrad
Physical	$75.00	
Office Procedure/Surgery	$75.00	
New Patient Visit	$75.00	
Massage	$40.00	

PLEASE KEEP IN MIND:

In order for our office to provide the best care possible, we ask that our patients make every effort to keep their scheduled appointments. If three (3) or more appointments are cancelled or missed without 24 hour notice, you may be dismissed from the practice.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Physicians Immediate Care and Medical Centers in regards to the above stated no show policy.

____
Signature of patient or legally authorized individual

____
Date

____
Printed Name of person signing

____
Patient date of birth

____
Printed name of patient if signed on behalf of patient

____
Relationship to patient
(parent, legal guardian, personal representative)