GREEN MOUNTAIN PARTNERS FOR HEALTH

PATIENT REGISTRATION HEALTH SUMMARY

Patient name (please PRINT):____ DOB:________________

Mailing Address: _____________________________________City:_____________State:___ Zip:______ Male __Female__

Marital Status:____________ Education:________________________ SSN_______________________

Email Address: ____ Employer Name _______________________________

Cell Phone #: (______) ______________Home Phone #: (______) ______________Work Phone #: (______) ______________

<u>Insurance Information</u> (Please provide your insurance card at the time of registration or if you have a policy change).

Please complete this section if patient is a minor (if patient is under the age of 18)
Responsible Party Name:_____________________________ ______________DOB:______________________

Relationship to Patient:______________________________ Primary Phone #: (______) __________________

Address:_________________________________ City:________________State:__________Zip Code:________

<u>Emergency Contact</u>
In case of an emergency, contact:_____________________________ Phone #: (______) __________________

Relationship to patient: ____

<u>Insurance Authorization and Assignment of Benefits:</u>
I hereby authorize payment directly to Green Mountain Partners for Health(GMPH), PLLC and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to GMPH. . Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs. I further understand that a monthly finance charge of 1.5% (18.00% annually) will be assessed on any unpaid balance.

Patient/Guardian Signature:_______________________________________ **Date:** __________________

(If patient is a minor, parent/legal guardian must sign on their behalf)
Relationship to patient: ____

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Patient name (please PRINT):____ DOB:____________________

ALLERGIES (and reaction) **NONE: __________**

MEDICATIONS **NONE: __________**

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the counter)?

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE		YES	NO	DISEASE
		Irregular Heart Beat				Prostate Problems
		Congestive Heart Failure				Gout
		Heart Attack				Arthritis
		Heart Murmur				Skin Disease, Type:
		Rheumatic Fever				Stroke
		High Cholesterol				Epilepsy/Seizures
		High Blood Pressure				Diabetes/High Blood Sugar
		Asthma				Thyroid Problems – too high or too low
		Emphysema/Chronic Bronchitis				Anemia/Low Blood
		Blood Clot in Lung				Bleeding Problems, Type:
		Blood Clot in Leg				Blood Transfusion
		Tuberculosis				Cancer, Type:
		Gallstones				Anxiety
		Liver Disease, Type:				Depression
		Ulcers in Bowel/Stomach				Glaucoma
		Bleeding from Bowels				Other:
		Kidney Disease, Type:				Other:
		Kidney Stones				Other:

SURGERIES

YES	NO	DISEASE		YES	NO	DISEASE
		Cataract Surgery, Left Right				Joint Replacement of Knee / Hip
		Tonsils Removed				Back Disc Surgery
		Neck Artery Surgery				Prostate Surgery
		Open Heart Surgery/Catheterization				Hernia Surgery
		Appendectomy				Vasectomy
		Gallbladder Removal				Hysterectomy
		Abdominal Surgery				Other:
		Broken Bone Repair				Other:
		Joint Scope Surgery				Other:

Patient name (please PRINT):____ DOB:____________________

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU		YES	NO	DISEASE	RELATION TO YOU
		Heart Attack					Bleeding Problems	
		High Blood Pressure					Sickle Cell Anemia	
		High Cholesterol					Diabetes/High Blood Sugar	
		Asthma					Thyroid Problems	
		Tuberculosis					Cancer, Type:	
		Liver Disease					Cancer, Type:	
		Kidney Disease					Alcohol Abuse	
		Gout / Arthritis					Anxiety	
		Osteoporosis					Depression	
		Stroke					Glaucoma	
		Epilepsy / Seizures					Other:	

OTHER HISTORY

Exercise: _____ Days per week Type of exercise:___________________

When was your last: Tetanus _______ Hepatitis B _______ Pneumovax _______ HPV _________ MMR_________
Shingles Vaccine________

Smoking:
Have you ever smoked: ___ Yes ___ No How many years did you smoke? _______ When did you quit? _______
How many packs per day do you smoke now? _______ Do you use smokeless tobacco: ___ Yes ___No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:
__ Yes __ No Do you drink? How much? _______ How often? _______
__ Yes __No Do you use drugs? How much? _______ How often? _______ What kind? ______________________

What drugs have you used in the past?____

FEMALE PATIENTS ONLY

of Pregnancies: _______ # of Deliveries: _______ # of Elective Abortions: _______ # of Miscarriages: _______

When was your last menstruation? ____________________ How old were you when you went through Menopause? __________

When was your last Pap smear? ______________________ Have you ever had an abnormal Pap smear? __ Yes __No

If “Yes,” when was the abnormal Pap smear? ____

What was the abnormality? ____

What kind of treatment did you have?____

When was your last Mammogram? ____________________ Have you ever had an abnormal Mammogram? __ Yes __No

If “Yes,” when was the Mammogram? ____

The above information is current and correct to the best of my knowledge.

I have reviewed the above history.

____ ____________________
Patient/Guardian Signature **Date**

__________________________ ________________
Physician’s Initial **Date**