**AMANA MEDICAL CENTER -- REGISTRATION INFORMATION**

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| **PATIENT INFORMATION**First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: [ ]  M [ ]  F Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_ Marital Status: [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widowed [ ]  SeparatedEmployer and Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student Status: [ ]  Full Time:[ ]  Part Time Name of School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to You: [ ] Spouse/Partner [ ] Parent [ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to Contact in Case of Emergency? [ ] Yes or [ ] No\*\*At which telephone number should we leave reminder calls (CHOOSE ONE)? [ ] Cell  [ ] Home  [ ]  Email  [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **INSURANCE INFORMATION**Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group/Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber or I.D. Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group or Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber or I.D. Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MEDICAL HISTORY**Current Medical Conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospitalization & Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Family history of medical conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Your Pharmacy Name & Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal history of past medical condition: Have you ever been told you had one of the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Condition** | **Yes** | **No** | **Comments / Notes**  | **Medical Condition** | **Yes** | **No** | **Comments / Notes** |
| Anxiety, Depression, ADHD |  |  |  | Heart trouble |  |  |  |
| Arthritis |  |  |  | Hepatitis |  |  |  |
| Any form of cancer |  |  |  | Lung disorder |  |  |  |
| Blood disorder |  |  |  | Life-threatening conditions |  |  |  |
| Diabetes |  |  |  | Nervous disorder |  |  |  |
| Defect or deformity |  |  |  | Spine disorder |  |  |  |
| Digestive Disease /Colon |  |  |  | STDs or Contagious disease |  |  |  |
| Disease of the kidney |  |  |  | Thyroid Disease |  |  |  |
| High blood pressure |  |  |  | Vision or hearing disorders |  |  |  |
| Smoking or marijuana |  |  | \_\_\_\_ Pk/Day \_\_\_ yrs | Alcohol |  |  |   |
| Other Conditions |  |

**ASSIGNMENT AND RELEASE**I hereby assign, transfer, and set over to **Amana Medical Center** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.Patient’s (or Responsible Party/Guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How did you find about us? \_\_\_\_Internet \_\_\_\_Friend \_\_\_\_Insurance company \_\_\_Ad \_\_ Business Card \_\_\_Walk In \_\_\_ Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |