Salina Regional Gastroenterology Clinic
Salina Regional Health Center

Dr. Christopher Wood
Dr. Jacob Wendling
501 S. Santa Fe, Ste 220
Phone: (785) 452-6440
Fax: (785) 452-6441

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Age: _____ Sex: _____

Birth Date: _____-_____-_____ SSN: _____-_____-_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

( )Single ( )Married ( )Widowed ( )Divorced ( )Other:_____

Preferred Language: ( )English ( )Spanish ( )Other:_____

Religion: _____ Affiliation: _____

Primary Physician: _____
Last Name First Name

Referring Physician (if different than primary physician): _____

EMPLOYMENT

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed ( )Disabled ( )Minor

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____ (Ext: _____)

PERSON RESPONSIBLE FOR BILL

( )Same as Patient ( )Parent/Guardian Other: _____

(If other than patient please fill in the following information)

Name: _____ Relation:_____

Birth Date: _____-_____-_____ SSN: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed ( )Disabled

Employer: _____

Address: _____

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INSURANCE

Is your visit a result of an injury? (Please choose one) ( )**Yes** ( )**No**

Primary Insurance: _____

Policy Holder: ( )Same as Patient ( )Spouse ( )Parent/Guardian Other: _____

(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Policy Number: _____ Group Number: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

DOB of insured: _____-_____-_____ SSN of insured: _____-_____-_____

Sex of insured: _____

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed ( )Disabled

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____ (Ext: _____)

Secondary Insurance: _____

Policy Holder: ( )Same as Patient ( )Spouse ( )Parent/Guardian Other: _____

(If other then patient please fill in the following information)

Name of Insured (policy holder): _____

Policy Number: _____ Group Number: _____

Address of Insured: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

DOB of insured: _____-_____-_____ SSN of insured: _____-_____-_____

Sex of insured: _____

( )Full-time ( )Part-time ( )Retired ( )Self-Employed ( )Unemployed ( )Disabled

Employer: _____

Address: _____

City: _____ State:_____ Zip: _____ Phone: _____ (Ext: _____)

*****We cannot file insurance without a copy of your insurance cards for verification of coverage.*****

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EMERGENCY INFORMATION

Next of Kin: _____

Relationship to patient: ( )Spouse ( )Parent/Guardian Other: _____

( ) Address is same as patient ( ) Different address (*please fill in the following information*)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Person to Notify (Nearest friend or relative): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Relationship to patient: ( )Spouse ( )Parent/Guardian Other: _____

I hereby authorize my provider to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original. I hereby authorize payment directly to my provider for this illness or injury, of the provider'sbenefits otherwise payable to me, but not to exceed my indebtedness to said provider. I agree to pay the provider for all my charges whether or not covered by this assignment. The responsible party hereby agrees that the provider's office or the party responsible for the billing of these services may check credit with any source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information which may be considered a communicable or venereal disease which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome(AIDS). I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations.

I have been notified that I may receive services from the Advanced Practice Provider at this location.

PLEASE NOTE: The patient portion of the bill is due at the time of service unless prior arrangements have been made.

x_____ **x**_____

Patient or Authorized Person's Signature *Date/Time*

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MEDICAL HISTORY

Current Complaints: (check to the left of all that apply)

	Difficulty Swallowing		Painful Swallowing		Weight Gain		Maroon Colored Stool
	Abdominal Pain		Blood in Stool		Weight Loss		Fever
	Changes in Appetite		Constipation		Diarrhea		Bloating
	Mucous in Stool		Heartburn		Nausea		Laxative Use
	Vomiting		Regurgitation		Belching		Other:_____

Past Medical History

Previous or current illnesses: (Check to the *left* of all that apply)

	Arthritis		Hypothyroidism		Coronary Artery Disease
	Diabetes		Hyperthyroidism		Congestive Heart Failure
	Stroke		Hypertension		Coronary Stents
	Ulcers		COPD/Emphysema		Hyperlipidemia
	GERD		Heart Attack		Hernia (type:_____)
	Colitis		Crohn's		Diverticulosis
	Hepatitis		Irritable Bowel Syndrome		Polyps
	Liver Enzyme Abnormalities		Cancer (type:_____)		Other:_____

Anticoagulant Use: ( )None ( )Plavix ( )Pradaxa ( )Aspirin ( )Coumadin ( )Other:_____

Surgical History

Surgery	Year	Surgery	Year

Last Mammogram: (Date/Year)_____/_____ ( ) Normal ( ) Abnormal

Last Colonoscopy: (Date/Year)_____/_____ ( ) Normal ( ) Abnormal

Social History

Do you drink alcohol? ( )Yes ( )No Amount per day? _____ What kind of alcohol?_____

Have you ever used street or IV drugs? ( )Yes ( )No What kind?_____

Do you use tobacco products? ( )Yes ( )No ( )Former Amount per day:_____ Quit Date:_____

Family History: Does anyone in your family have (or have had):

*Check all that apply and specify **who, what kind,** and at **what age**?*

		Who	*Details*	*Age*
	Heart Problems			
	Blood Clotting Problems			
	Cancer			
	Lung Problems			
	Diabetes			
	Bowel Disorders			
	Other			

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TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGEMENT

Salina Regional Health Center Physician Clinics, including its acute care rehabilitation unit, emergency departments, outpatient surgery and outpatient departments are herein referred to as "medical group".

1.CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. Further, I understand that among those who attend patients at this medical group are medical, nursing, and other health care personnel in training and volunteer student observers who, unless requested otherwise, may be present during patient care as a part of their education. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by me or my family and the medical group shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. CONSENT FOR BLOOD/BODY FLUID TESTING: In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the medical group determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

3. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS: I agree that the medical group may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

4. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as a patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the medical group in accordance with its regular rates and terms.

5. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign my insurance benefits otherwise payable to me to be paid directly to the medical group. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable cost of collection, including but not limited to attorney fees and collection agency fees.

6. MEDICARE/MEDICAID/INSURANCE BENEFITS: I authorize the medical group to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the medical group for services furnished me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital.

7. AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES & WAIVER OF ACCOUNTING: I understand that as part of its health care operations, the medical group is required by law to disclose certain of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize the hospital to make such disclosures without any accounting of such disclosures since they are required by law.

8. CONTRABAND WEAPONS/DRUGS: I agree that should the medical group find contraband weapons and/or nonprescription drugs not sold over-the-counter with my possession, these items will be confiscated and the police will be contacted.

9. TOBACCO PRODUCTS: Salina Regional Health Center is a tobacco free campus. Tobacco use is prohibited on all hospital owned properties including outdoor areas, stairways, parking lots and garages, medical office building properties and entryways. Please send your smoking materials home. If you do smoke, please consider asking your nurse regarding information on smoking cessation programs.

10. PROVIDER NON-DISCRIMINATION ACT: I understand that this is an equal opportunity institution.There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

11. PATIENT RIGHTS INFORMATION: I have reviewed/received "Patient Right and Responsibilities" and understand my rights as described in that document.

12. NOTICE: Your health information related to work-related illnesses/injuries or to medical surveillance of the work place may be disclosed to your employer.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

X_____
PATIENT/PERSONAL REPRESENTATIVE INITIAL

13. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.
I hereby acknowledge that I have received a copy of the medical group's Notice of Privacy Practices.

X_____
PATIENT/PERSONAL REPRESENTATIVE INITIAL

I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

x_____ _____ _____
Patient/Personal Representative Signature *Relationship to Patient* *Date*

x_____ _____
Signature, Witness *Date*

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Salina Regional Health Center Contact List
Authorization to Verbally Release Protected Health Information Contact List:

I authorize Salina Regional Health Center, and all affiliates, health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, caretakers, concerning my health care will not be disclosed without an additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Name of Family Member/Caretaker	Relationship	Phone Number	Allow Messages
_____	_____	_____	Y / N
_____	_____	_____	Y / N
_____	_____	_____	Y / N

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

X_____ X_____

Date *Signature of Patient or Authorized Agent/Representative*

_____ _____

Printed name of authorized agent/representative *Relationship to patient*

_____ _____

Address of Authorized agent/representative *Telephone # of authorized agent/representative*

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")

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Prescription and Non-Prescription Medication List

Preferred Pharmacy:_____

Allergies:_____

Medication Name	*Dosage*	*How often are you taking?*	*What is the medication for?*