# First Visit Registration Form

**Please Print**

| | |
|---|---|
| Social Security no. | Member ID no. (as shown on insurance card) |

| | | |
|---|---|---|
| First Name | Middle Initial | Last Name |

| | |
|---|---|
| Date of Birth<br>/ / | Marital Status *(circle one)*<br>Married Single |

| | |
|---|---|
| Address | Apt # |

| | | |
|---|---|---|
| City | State | Zip |

| | |
|---|---|
| Phone No. | Cell Phone No. |

| | |
|---|---|
| Email address | Please Sign Here: |

| | |
|---|---|
| In case of Emergency – who should be notified: *(please put full name)* | |
| Their phone no. | Relation to you |
| What is the reason for your visit today? | |
| What are your symptoms and how long have you had these symptoms? | |

MEDICAL HISTORY FORM

Date_____ Date of Birth_____

Last Name_____ First Name_____ Middle Initial_____

| List prescribed and over the counter medications, including vitamins | | |
|---|---|---|
| Medication | Dosage | How often |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| List any allergies you may have | No Allergies ☐ |
|---|---|
| | |
| | |
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| | |
| | |

GENERAL MEDICAL HISTORY

Do you currently or have you previously been TREATED for any of the following: No Medical Problems ☐

| | Yes | No | | Yes | No | | |
|---|---|---|---|---|---|---|---|
| Allergies/Hay fever | | | Kidney Infections-recurrent | | | | |
| Asthma | | | Kidney Stones | | | Surgical History | No Surgery ☐ |
| Bronchitis - Recurrent | | | Liver Disease | | | | |
| Cancer Type- | | | Prostate Problems | | | | |
| Depression or Anxiety | | | Skin Disorders | | | | |
| Diabetes ☐ Type I ☐ Type II | | | Sleep Apnea | | | | |
| Diabetes Gestational | | | Stomach Ulcer | | | | |
| Emphysema | | | Stroke or TIA's | | | | |
| Fast/Irregular heart beat | | | Thyroid Problems | | | | |
| Heart Attack | | | Other Bowel Problems | | | | |
| Heart Murmur | | | Other Lung Problems | | | | |
| Hepatitis | | | Other Heart Problems | | | | |
| High Blood Pressure | | | Other Kidney/Urinary Problems | | | | |
| High Cholesterol | | | | | | | |
| Heart Disease | | | Do you wear Glasses/Contacts | | | | |
| Irregular heart beat | | | Do you wear a hearing device | | | | |

CHECK ANY OF THE FOLLOWING THAT YOU HAVE BEEN TESTED FOR:

| Test | Normal | Abnormal | Year | Test | Yes | No | Date |
|---|---|---|---|---|---|---|---|
| Eye Exam | | | | Last Full Physical | | | |
| Cholesterol | | | | Pneumonia shot | | | |
| Heart Testing | | | | Flu shot | | | |
| Treadmill Stress Test | | | | | | | |
| Echo cardiogram | | | | Pap Smear | | | |
| EKG | | | | Birth Control | | | Type |
| Colonoscopy | | | | Date of Last Period | | | |
| Osteoporosis Testing (DEXA) | | | | Number of Pregnancies | | | |
| Prostate Blood Test (PSA) | | | | Number of Miscarriages | | | |
| Prostate Exam | | | | Number of Living children | | | |

SOCIAL HISTORY (CHECK THE ONES THAT APPLY TO YOU)

| Marital Status | | Tobacco Use | Yes | No | Drug Use | | Alcohol Use | | Exercise | |
|---|---|---|---|---|---|---|---|---|---|---|
| Single | | | | | | | None | | None | |
| Married | | Packs per day | | | Never | | Minimal | | Occasionally | |
| Separated | | Cans per day | | | Previous use | | Moderate | | Weekly | |
| Divorced | | How many years | | | Current use | | Heavy | | Daily | |
| Widowed | | | | | | | Previous use | | Occupation | |

FAMILY HISTORY (IMMEDIATE FAMILY ONLY THAT INCLUDES: FATHER, MOTHER, SISTERS, BROTHERS)

| | Yes | No | If "YES" please explain type of problem and their age when diagnosed |
|---|---|---|---|
| Cancer | | | |
| Bleeding disorders | | | |
| Diabetes | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| Mental Illness | | | |
| | | | |

# Acknowledgement of Receipt of Notice

**IMWell Health, LLC**
808 N 161st E Ave
Tulsa, OK 74116
Phone: 918-270-9612

I hereby acknowledge that I received or read a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

Patient Name: _____ Patient Date of Birth: _____

If not signed by the patient, please indicate.

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

_____

***For Office Use Only*:**

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

# Authorization for the Use or Disclosure of Protected Health Information
# (Release of Medical Records)


## IMWell Health, LLC

7215 Cameron Park Dr
Fort Smith, AR 72903
Phone: 479-434-3431/Fax: 479-434-3466


**As required by the Health Insurance Portability and Accountability Act of 1996 our office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.**

**AUTHORIZATION SECTION**

I, _____(print patient's name) D.O.B. _____/_____/_____,

SSN#_____ hereby authorize the use and disclosure of the following health information that pertains to me:

_____ All my medical records _____Records for Dates of Service _____/_____/_____ to _____/_____/_____

_____Lab Reports _____X-Ray (Information type, or numbered list of multiple types of information)

_____

_____OP Reports _____History & Physicals _____Shot Records

**For the following purpose(s):**

____ Transfer of Care to another Physician ____ Personal Use

____ Insurance Application ____ Coordination of care w/ another Physician w/out transfer of care

**I authorize _____to make these disclosures of my health information.**

**I authorize _____ to receive these disclosures of my health information**.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the address above. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

**I understand that this authorization will automatically expire on _____/_____/_____.**

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that the clinic named above will not receive compensation for the uses and disclosures that I have authorized.

_____ _____
Signature/Patient, Parent or Guardian Date

_____
Print Name

**REVOCATION SECTION**

I hereby revoke this authorization. _____ _____
Signature Date

Revocation received by clinic: _____ _____
Signature Date

Copy Given to Patient _____
(signature of employee)