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Patient Registration *(please print clearly)*

☐ Cedarwood ☐ Douglas ☐ Greater Glendale ☐ Illinois Valley ☐ Rogue

Last Name: _____ First: _____ Middle: _____

Preferred Name: _____ Date of Birth: _____ Birth Sex: ☐ Male ☐ Female

SSN: _____ Driver License #: _____ Preferred Language: _____

I identify as: ☐ Female ☐ Female-to-Male Transgender ☐ Non-Conforming
☐ Male ☐ Male-to-Female Transgender
☐ Other: _____ ☐ Decline to answer

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ African American
☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell Email: _____

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

Preferred Pharmacy: _____ Appointment Reminders OK? ☐ Yes ☐ No

Ok to leave message on: Home? ☐ Yes ☐ No Work? ☐ Yes ☐ No Cell? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Primary Insurance: _____ Policy #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION

Policy Holder: _____ DOB: _____ SSN: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize AllCare Health Group to provide my insurance companies with all information necessary to process insurance claims and assign payments to AllCare Health Group all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original. I have read and understood all of the above.

Signature: _____ Date: _____

AllCare Medical Group
1701 NE 7th Street, Grants Pass, OR 97526
Phone (541) 471-4106 | Toll free (888) 460-0185 | TTY 711 | Language access (888) 260-4297

Authorization for Communication of Protected Health Information to Family and Friends

Patient Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone Number _____

Address _____ City _____ State _____ Zip _____

I, _____, authorize AllCare Medical Group to discuss/share my protected health information with the following individual(s):

Name	Relationship	Phone Number

Type of information to be shared or disclosed:

- ☐ Appointment Information
- ☐ Medical Information
- ☐ Prescription Information
- ☐ Mental Health Information
- ☐ Lab/Imaging Results
- ☐ Any Information

☐ **I do not authorize** AllCare Medical Group to share my protected health information with any individuals.

I authorize AllCare Medical Group to leave detailed messages about my medical and health information on the following:

- ☐ Cell Phone Voicemail
- ☐ Home Phone Voicemail

Signature: _____ Date: _____

(This authorization shall remain in effect until revoked by the patient or for 1 year. You may request a new form at any time. Submitting a new form will replace the existing form.)

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Medical Record Release

I hereby authorize:

Name of disclosing party

Address

City | State | Zip

To disclose to:

Name of recipient

Address

City | State | Zip

RECORDS AND INFORMATION FOR THE PAST TWO (2) YEARS PERTAINING TO:

Patient name (list other names used) | SSN | Date of Birth

Address | Phone number

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- ☐ Medical information _____ (initials)
- ☐ Psychiatric information _____ Signature _____ Date
- ☐ Drug/Alcohol Information _____ Signature _____ Date
- ☐ Results of HIV Test _____ Signature _____ Date
- ☐ Genetic Records _____ Signature _____ Date
- ☐ Other Health Information _____ (initials and specify below)
- ☐ Specify the records to be disclosed: _____

This authorization ☐ **does** / ☐ **does not** discontinue my care through AllCare Medical Group.

The recipient may use the health information authorized on this form for the following purposes:

_____

Signature | Date | If signed by other than patient, indicate relationship

(A copy of this authorization is as valid as the original. Patient has a right of receive a copy of this authorization.)

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Health History

Patient Name: _____ Date of Birth: _____

Who was your last primary care provider? _____

Please list other Health Care Providers or Specialists you are currently seeing as a patient:

_____

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR THE FOLLOWING

- ☐ Anemia
- ☐ Angina/Heart Attack
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots | Location: _____
- ☐ Bipolar Disorder
- ☐ Blind/Vision Issues
- ☐ Cancer | Type: _____
- ☐ Chronic Kidney Disease
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Deaf/Hearing Issues
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Esophageal/GERD
- ☐ Excessive Snoring/Sleep Apnea
- ☐ Fibromyalgia
- ☐ Heart Failure
- ☐ Heart Valve Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Painful Menses
- ☐ Prostate Enlargement
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Vascular Disease
- ☐ Migraine

MEDICATIONS

Do you have any trouble taking any of your medications? ☐ Yes ☐ No

(If you need more room to list additional medications, please write them on a blank sheet of paper with the required information)

Medications *(please list all)*	Dose *(Mg., pill, etc.)* and Frequency *(once daily, twice, etc.)*

ALLERGIES

Allergies *(environmental, food, drug)*	Reaction *(symptoms)*

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Health History *(continued)*

FAMILY HISTORY

Father (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Mother (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Brother/Sister (Living: ☐ Yes ☐ No) Age: _____ Health: _____

Children How Many: _____ Age: _____ Health: _____

LIFESTYLE

Occupation: _____

Married Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partnership ☐ Widowed

Caffeine: How much caffeine do you consume per day? (e.g. coffee, tea, chocolate, soda) _____

Alcohol

How many drinking days do you have per week? _____ On average, how many drinks per drinking day? _____

Are you or others concerned about your drinking? ☐ Yes ☐ No

Tobacco and Vape Use

Do you currently use any forms of tobacco or do you vape? (please specify what type) _____

If yes, how frequently is your usage? _____ Are you interested in quitting? ☐ Yes ☐ No

Drug Use

Do you have a history of Drug use? ☐ Yes ☐ No (if yes, what substance) _____

Do you have problems with walking or balance? ☐ Yes ☐ No

PREVIOUS SURGERIES (if additional surgeries attach an additional sheet of paper)

	Type	**Year**
1		
2		
3		
4		

Date of Last Colonoscopy: _____ Date of Last Bone Density: _____

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

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Health History *(continued)*

Men Only

Date of last PSA test: _____

Diabetic Patients

Date of last foot exam: _____ Date of last eye exam: _____

Date of last A1c: _____ Date of last cholesterol panel: _____

LIFESTYLE

Exercise/Activity

What Type of Exercise do you do (example: walking, swimming, running)? _____

How long? _____ How often? _____

Falls

Have you fallen in the past year? ☐ Yes ☐ No

Do you have problems with walking or balance? ☐ Yes ☐ No

Safety

Are you in a relationship that makes you feel unsafe or have been hurt? ☐ Yes ☐ No

Do you regularly wear a seatbelt? ☐ Yes ☐ No

HIV Testing

Would you like HIV testing? ☐ Yes ☐ No (If yes, please tell the Medical Assistant). HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Hepatitis C Testing

Have you ever been tested for Hepatitis C? ☐ Yes ☐ No

The United States Preventative taskforce recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years at least once in a lifetime.

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Review of Symptoms

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

Constitutional Symptoms
- ☐ Fever
- ☐ Weight loss
- ☐ Extreme fatigue

Eyes
- ☐ Double vision
- ☐ Sudden loss of vision

Ears, Nose, Mouth, and Throat
- ☐ Sore throat
- ☐ Runny nose
- ☐ Ear pain

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools

Genitourinary
- ☐ Irregular menses
- ☐ Bloody urine
- ☐ Vaginal bleeding after menopause
- ☐ Frequent or painful urination
- ☐ Impotence

Skin
- ☐ Rash
- ☐ Changing Mole

Sleep
- ☐ Snoring
- ☐ Difficulty sleeping

Neurological
- ☐ Headache
- ☐ Persistent weakness on one side of the body
- ☐ Falling

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

Endocrine
- ☐ Excessive thirst
- ☐ Cold or heat intolerance
- ☐ Breast mass

Hematologic
- ☐ Unusual bruising or bleeding
- ☐ Enlarged lymph nodes

Allergic
- ☐ Hay fever

IF YOU HAVE ONE OF THE FOLLOWING CONDITIONS PLEASE ANSWER:

Diabetes
Any problems with medications? ☐ Yes ☐ No Home glucose readings: _____

High Blood Pressure
Any problems with medications? ☐ Yes ☐ No Home blood pressure readings: _____

High Cholesterol
Any problems with medications? ☐ Yes ☐ No

Depression
Any problems with medications? ☐ Yes ☐ No Any suicidal thoughts? _____

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Review of Symptoms *(continued)*

Please identify any issues on this form which are new or that you specifically want to address:

If you need help between appointments, please call your office location.

Our goal is to see you the day you call in or the next day. It is helpful if you call first thing in the morning. One of our nurses will help you decide if you need to be seen and if any tests are needed prior to your appointment.