**Integrative Care, LLC**
**10404 W. Coggins Dr. Sun city, AZ 85351**
**P (623) 972-1055 F (623) 972-1185**

# PATIENT REGISTRATION

First Name:_____ Last Name:_____ Middle Initial:_____

DOB:_____ Social Security #_____

Home Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____

Sex: Male___ Female_____ Marital Status: Married_____ Single_____ Widowed_____ Divorced_____

**(Policy Holder Information)**

First Name:_____ Last Name:_____ Middle Initial:_____

DOB:_____ Social Security #_____

Home Address:_____City_____State_____Zip_____

Home Phone:_____ Cell Phone:_____

**Primary Insurance**

Insurance Name_____

Policy #_____

Group #_____

Insurance Phone_____

**Secondary Insurance**

Insurance Name_____

Policy #_____

Group #_____

Insurance Phone_____

Do you have a third insurance? Yes No, If yes what insurance

Insurance Info_____

**Past Medical History**

Alcoholism, Chest Pain, Back Pain, Neck Pain, Migraines, Headaches, Arthritis, Hepatitis, Bronchitis, Sinusitis, Pancreatitis, Blood Disease, Heart Disease, Skin Disease, Thyroid disease, Liver Disease/ Cirrhosis, Venereal Disease, Cancer, Tumor, Stroke, Heart Attack, High Blood Pressure, Diabetes, Depression, Lung Problem, Kidney Problem, Psychiatric Problems, Gallstones, German Measles, Glaucoma, Gout, Fibromyalgia, Fibrocystic Breast, Emphysema, Epilepsy, Hemorrhoids, Hernias HIV,UTI infections, other_____

**Surgical History**

Type and year_____

_____

_____

**Preventive care**

Women

Last Pap smear_____

Last mammogram_____

Men

Last Prostate_____

Last colonoscopy_____

**Social history**

Tobacco use: Yes or No

Alcohol use: Yes or No

Do you drink caffeine: Yes or No

Do you use recreational drugs: Yes or No

Do you practice safe sex? Yes or No

Do you wear a seat belt? Yes or No

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Print Name:_____

Sign: _____ Date:_____

**Advanced Directive**

Do you have a living will____ Power of Attorney ___ DNR (Do Not Resuscitate)___ Other ____

If you have any of the above please provide us with copies.

## Medication List

| Medication Name | Dosage | Frequency |
| --- | --- | --- |

## Allergies