CROSS TRAILS MEDICAL CENTER
Patient Registration Form

Revised 3/25/2(

Patient Information

Last Name	First Name	MI	Social Security Number
/ /	M / F	Single / Married / Widowed / Divorced	
Birthdate	Sex	Marital Status	

Address		
City	State	Zip Code
Home Phone	Cell Phone	Work Phone

Ok to leave message? Yes / No

Email Address:_____

Emergency Contact	Relationship to Patient	Home Phone	Work Phone

Responsible Party Information (if other than the patient)

Last Name	First Name	MI	Social Security Number
/ /	M / F	Single / Married / Widowed / Divorced	
Birthdate	Sex	Marital Status	

Address		
City	State	Zip Code
Home Phone	Cell Phone	Work Phone

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Revised 3/25/2024

Do you have a preferred pharmacy? Yes / No

Pharmacy:_____ Phone Number:_____

Address:_____

FOR PRIVATE INSURANCE PATIENTS -
Cross Trails Medical Center utilizes our in-house laboratory to process any labwork you may need.
If your insurance company requires your lab work to be sent to a specific lab please indicate below.

Cross Trails	**Southeast Hospital Lab**
LabCorp	**St. Francis Lab**
Quest	**Other (please specify)_____**

Authorization : I hereby authorize the physician above to furnish information to insurance carriers concerning myself and my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance.

Authorization : I hereby authorize payment of medical benefits to Cross Trails Medical Center.

Authorization : I hereby give permission for laboratory treatments and procedures, health history and physical assessment, mental health evaluation and treatment to be performed.

Authorization : I hereby request that my medical records, laboratory results, x-ray results and all pertinent information be released to Cross Trails Medical Center.

_____ _____

Date Signature of patient, parent or guardian

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Revised 3/25/202

DUE TO GOVERNMENT REGULATIONS WE ARE REQUIRED TO ASK ALL PATIENTS THE FOLLOWING QUESTIONS:

1.Preferred Language

- [ ] English
- [ ] Spanish
- [ ] Other:_____
- [ ] Choose Not to Disclose

2. Race: (Select All that Apply)

- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian
- [ ] Native Hawaiian
- [ ] Other Pacific Islander
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Black/African American
- [ ] White
- [ ] Choose Not to Disclose

3. Ethnicity:

- [ ] Mexian, Mexican American, Chicano/a
- [ ] Puerto Rican
- [ ] Cuban
- [ ] Not Hispanic or Latino
- [ ] Another Hispanic, Latino/a Spanish Origin
- [ ] Choose Not to Disclose

4. Are you a Veteran?

- [ ] Yes
- [ ] No

5. What is your Education Level?

_____

6. Are you a Migratory Agriculture Worker?

- [ ] Yes
- [ ] No

7. Are you a Seasonal Agricultural Worker?

- [ ] Yes
- [ ] No

6. Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Choose Not to Disclose

7. Sexual Orientation

- [ ] Straight or Heterosexual
- [ ] Lesbian, Gay, Homsexual
- [ ] Bisexual
- [ ] Other
- [ ] Don't Know
- [ ] Choose Not to Disclose

8. Gender Identity

- [ ] Female
- [ ] Male
- [ ] Transgender Female
- [ ] Transgender Male
- [ ] Other
- [ ] Choose Not to Disclose

9. Gender Assigned at Birth

- [ ] Female
- [ ] Male

10. Family Size and Income:

Family Size	#
Annual Income for Family	$
Choose Not to Disclose	

11. Housing Status

- [ ] Not Homeless
- [ ] Homeless Shelter
- [ ] Permanent Supportive Housing
- [ ] Doubling Up
- [ ] Street
- [ ] Transitional
- [ ] Other
- [ ] Unknown

Appointment Policy

We have more patients desiring treatment each month than we can appoint. If you have an appointment, someone else did not get one. Therefore, if you miss your appointment and do not let us know at least 24 hours ahead, we cannot get someone else scheduled for your time. For this reason, we have had to initiate a broken appointment policy which in summary says:

If you miss 2 appointments without giving sufficient prior notice, you cannot get another routine appointment for at least 12 months.

Emergency care will still be provided on a same day scheduled appointment. If you are 15 minutes late for an appointment, and it would cause another patient to have to wait excessively long, it will be considered a broken appointment and the above policy will be followed.

When you arrive at the clinic, please check in with the receptionist.

You are required to pay for services up front at each visit understanding this is an estimate of charges. You will be expected to pay any additional charges before your next visit. If you do not have your payment at the time of the visit you will be rescheduled.

Medication Refill Policy

It is the policy of Cross Trails Medical Center that medication refills requires a 48 hour advance notice.

I understand the appointment and medication refill policy at Cross Trails Medical Center and will abide by it.

Patient's Name:_____

Signature:_____
(Parent or guardian if minor)

Date:_____

Cross Trails Medical Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

CROSS TRAILS MEDICAL CENTER

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information. Your protected health information will be used by Cross Trails Medical Center or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices. Cross Trails Medical Center is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Practices" brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information. You may request a restriction on the use or disclosure of your protected health information. Cross Trails Medical Center may or may not agree to restrict the use or disclosure of your protected health information. If Cross Trails Medical Center agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be violation of the federal privacy standards.

Revocation of Consent. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices. Cross Trails Medical Center reserves the right to modify the privacy practices outlined in the notice. I understand that Cross Trails Medical Center will notify me of these changes via the method I have authorized or upon my next appointment.

RELEASE OF INFORMATION

I authorize Cross Trails Medical Center to release medical information about my treatment and care to:

_____ Spouse	_____ Parent(s)
_____ Sister/Brother	_____ Physician
_____ Children	_____ Physician
_____ Other	_____ Other

_____ _____ _____

Patient Name Date of Birth Date

_____

Patient Signature

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

_____ _____ _____

Signature DOB Date

Cross Trails Medical Center
Clinical Assessment Summary

The information collected from this form, will help our providers better serve you as a patient. If you had services at other facilities other than Cross Trails Medical Center, please complete the attached medical record release form so we may better serve you. Thank you for choosing Cross Trails Medical Center as your Medical Provider.

TODAY'S DATE: _____

NAME: _____ **DOB:** _____

ADVANCE DIRECTIVE

In the event you should have a cardiac arrest or a life threatening event, do you want to be resuscitated? **Yes or No**

If you answered no, do we have a copy of your advance directive? Yes or No.

If you answered no, and you'd like for us to have a copy, please fill out a medical release form so we may get it from the facility who has it, or ask the front desk for the paper work.

1. Do you have Asthma? **Yes or No**
   If you answered yes, do you see us for your Asthma? **Yes or No**
   If you do not see us for your asthma, who do you see?_____

2. Do you have Heart problems? **Yes or No**
   If you answered yes, do we see you for your heart problems? **Yes or No**
   If you do not see us for your heart problems, who do you see?_____

3. Do you have Diabetes? **Yes or No**
   If you answered yes, do we see you for your diabetes care? **Yes or No**
   If you do not see us for your diabetes, who do you see?_____
   Have you had an eye exam ? **Yes or No**
   If you answered yes, who do you see for your eye exams? _____

4. Have you been hospitalized/seen in the emergency room since your last visit? **Yes or No**
   If yes, what hospital were you seen at ?_____

5. IF YOU ARE 45-75 YEARS OF AGE, PLEASE ANSWER QUESTIONS **5** and **6:**
   Have you had a screening for colorectal cancer? **Yes or No**
   If you answered yes and the screening was not completed at our office,
   please tell us who completed the screening. _____

6. In the past nine years, have you had a colonoscopy completed? **Yes or No**
   If you answered yes, who did your colonoscopy? _____

7. Do you have vision issues? _____ **Yes or No**

8. Do you have hearing issues? _____ **Yes or No**

9. Do you have memory issues? _____ **Yes or No**

SOCIAL DETERMINANTS OF HEALTH QUESTIONNAIRE

10. What is your current housing situation:
    Home
    Homeless
    Shelter
    Other:

11. Are you worried about losing your home: **Yes or No**

12. Do you have any financial barriers: **Yes or No**
    If you answered yes please mark the appropriate option(s) below

    Food Utilities Childcare Clothing Phone Legal Services

13. Do you feel socially isolated: **Yes or No**

14. How stressed are you:

    Not at all Sometimes Always

15. Do you have transportation: **Yes or No**

ANSWER THIS QUESTION IF YOU ARE FEMALE AND 21-64 YEARS OF AGE:

16. Have you had a pap smear completed in the past three years? **Yes or No**
    If yes, did we complete your pap smear? **Yes or No**
    If you do not see us for your pap smear, who do you see?_____
    If you have had a hysterectomy, was it a partial or total? Please list the month, year, and date._____.

ANSWER THIS QUESTION IF YOU ARE FEMALE AND 40-74 YEARS OF AGE:

17. Have you had a mammogram completed in the past two years? **Yes or No**
    If yes, who performed the mammogram? _____

CROSS TRAILS MEDICAL CENTER

PATIENT HISTORY
ADULT / GERIATRIC LIFECYCLE
(Age 20+ years)

Date Completed _____ /_____ /_____

NAME:_____ **DATE OF BIRTH** _____/_____/_____

MARITAL STATUS: SINGLE MARRIED DIVORCED CHILDREN:__ **OCCUPATION:**_____

PAST MEDICAL HISTORY **(please write down or check all that apply to you)**

☐ Unremarkable	☐ Crohn's Disease	☐ Hepatitis A	☐ Thyroid Disorder
☐ Asthma	☐ Chronic Renal Failure	☐ Hepatitis B	☐ Tuberculosis
☐ Atrial Fibrillation	☐ Depression	☐ Hepatitis C	☐ Valvular Heart Disease
☐ Anemia	☐ Diabetes-Type I	☐ Infertility	☐ UTI - Recurrent
☐ Autoimmune Disorder	☐ Diabetes-Type 2	☐ Kidney Disease	☐ Varicose veins/Phlebitis
☐ Biliary Cirrhosis	☐ Diverticulitis	☐ Kidney Stone	☐ Other Cancer
☐ Blood transfusions	☐ DVT	☐ Heart attack	☐ Pap Smear
☐ Brain Tumor	☐ GI Bleed	☐ Neurological Disorder	☐ Mammogram
☐ Cerebrovascular Disease	☐ GERD	☐ Osteoarthritis	☐ Eye Exam
☐ Cirrhosis	☐ Hemochromatosis	☐ Osteoporosis	
☐ CVA / Stroke	☐ Hyperlipidemia	☐ Peripheral Venous Disease	
☐ COPD	☐ Hypertension	☐ Peptic Ulcer Disease	
☐ Colon Cancer	☐ Hyperthyroidism	☐ Rheumatoid Arthritis	
☐ Coronary Heart Disease	☐ Hypothyroidism	☐ Seizure Disorder	

OTHER PAST MEDICAL HISTORY:_____

_____

PREVIOUS SURGERIES: **(please write down and/or check all that apply)**

- ☐ Unremarkable
- ☐ Abdominal Surg-type
- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Back Surgery
- ☐ Bronchoscopy
- ☐ Coronary Bypass Surgery
- ☐ Carpal Tunnel
- ☐ Cataract Extraction
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Knee arthroscopy
- ☐ Knee replacement
- ☐ Mitral Valve Replacement
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Rotator Cuff Repair
- ☐ Tonsillectomy
- ☐ Urinary incontinence surgery
- ☐ Colonoscopy
- ☐ Anesthesia Prob - NO
- ☐ Anesthesia Prob - YES
- ☐ Surgical Complications - NO
- ☐ Surgical Complications - YES

OTHER SURGERIES: _____

_____

FAMILY HISTORY (please write down or check all that apply to you) Health problem

Mother: ☐ ALIVE ☐ DECEASED at age _____ _____

Father: ☐ ALIVE ☐ DECEASED at age _____ _____

Sibling1: ☐ ALIVE ☐ DECEASED at age _____ _____

Sibling2: ☐ ALIVE ☐ DECEASED at age _____ _____

(Check for any known history)	PARENTS		GRANDPARENTS		SIBLINGS	
	Father	Mother	Fraternal FGM/FGF	Maternal MGM/MGF	Brother	Sister
Heart disease						
Heart attack						
Stroke						
Hypertension						
Diabetes Mellitus						
Breast Cancer						
Ovarian Cancer						
Colon Cancer						
Other						

SOCIAL HISTORY (please write down or check all that apply to you)

Smoking status ☐ Current ☐ Former ☐ Never ☐ Unknown

How many cigarettes do you smoke a day? 1 Pack _____ How long have you smoked? _____

Do you use smokeless tobacco? 1 Pack _____ How long have you used this? _____

Alcohol Use ☐ Yes ☐ No How much do you drink? _____

Drug Use ☐ Yes ☐ No What type of drugs do you use? _____

HIV/High Risk ☐ Yes ☐ No _____

Regular Exercise ☐ Yes ☐ No How many times a week do you exercise? _____

ALLERGIES:

_____

_____

MEDICATIONS **Dosage** **Instructions**

_____

_____

_____

_____

_____

_____

Pharmacy

_____