AURORA
whole family

PATIENT REGISTRATION INFORMATION

Name (First, Middle, Last) _____ Date _____

Birthdate _____ Gender _____

Parent(s) Names (If patient is a minor) _____

Address _____

City _____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Can we leave voicemails? _____ Can we send text appointment reminders? _____

E-mail _____Marital Status _____

Employer _____ Business Phone _____Occupation _____

In case of emergency, who should we contact? _____

Relationship _____ Phone _____

Preferred Pharmacy _____ Preferred Lab _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name_____ Insurance Phone _____

Insurance Company Address _____

Subscriber I.D. # _____ Group Number _____

Person Responsible for Account _____

Relationship to Patient _____ Social Sec. # _____ Birthdate _____

Responsible Party Employed By _____

ADDITIONAL INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company Name_____ Insurance Phone _____

Insurance Company Address _____

Subscriber I.D. # _____ Group Number _____

Person Responsible for Account _____

Relationship to Patient _____ Social Sec. # _____ Birthdate _____

Responsible Party Employed By _____

Who should we thank for referring you? _____

RELSEASE OF BILLING INFORAMTION

I hereby authorize payment directly to Aurora Family Health & Maternity Care Services for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services on my behalf or my dependents.

ASSIGNMENT OF BENEFITS

I authorize Aurora Family Health & Maternity Care Services and providers to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____Date _____

Aurora Family Health & Maternity Care Services, LLC

Patient Financial Agreement

As the patient or the patient's financial representative, you understand and agree to the following:

- Payment and/or copayment is due at the time of service. If copayment is not received at the time of service, a $10.00 fee will be assessed to the account.
- A $25 fee will be assessed on all returned checks.
- You are responsible for the account balance after 60 days regardless of insurance coverage.
- You are responsible for knowing your insurance coverage and benefits. It is your responsibility to make Aurora Family Health aware of any charges not covered by your insurance. As a courtesy, Aurora Family Health will bill your insurance and allow them 45 days to make payment. After 45 days, it is your responsibility to follow up with your insurance.
- You authorize care and treatment by Aurora Family Health and release of all information to insurance and third party carriers and direct them to remit payments directly to Aurora Family Health & Maternity Care Services.
- Accounts past 90 days will be charged interest at a rate of 1.5% monthly. A late fee of up to $20.00 per month may be charged to past due accounts.
- If the account is assigned to an agency for collections, it is agreed that the financial representative will pay all attorney fees, with or without suit, court costs, and a collection fee of up to 40% of the balance, which will be added to the outstanding balance of the account.
- Self-pay patients will receive services at a discounted rate if charges are paid in full at the time of service.
- A $50.00 fee may be assessed to the account if an appointment is cancelled with less than 24 hour notice.
- If you are cover under the Oregon Health Plan, it is your responsibility to confirm you are covered by Family Care. This is the ONLY OHP insurance we accept. If you are not on Family Care insurance, you will be responsible for pay for any/all services.

Signature of Patient: _____

Printed Name: _____ Date: _____

Signature of Financial Representative (if applicable): _____

Relationship to Patient: _____

Aurora Family Health & Maternity Care Services, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that Aurora Family Health has provided you with a copy of its Notice of Privacy Practices. You consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

For Personal Representative of Client (if applicable):

_____ _____

Print Name of Personal Representative Relationship to Patient

_____ _____

Signature of Personal Representative Date

Aurora Family Health & Maternity Care Services, LLC

Medical History

Name:	Date of Birth:	Today's Date

Allergies: Please indicate the reaction.

☐ None
☐ _____

Medications/Supplements -- Dosage – How often taken – Why are you taking this?

☐ None
☐ _____
_____
_____

Vaccines: Please list type and dates.

☐ None
☐ _____

Current Medical Problems: Please list any medical problems you are currently being treated for.

☐ None
☐ _____

Family History: Please indicate if any blood relatives have or have had any of the following.

☐ None

__Heart Disease
__Cardiovascular Disease
__Stroke
__Lung Disease
__Gastrointestinal Disease
__Cancer
__Diabetes
__Endocrine Disease
__Genetic Disorders
__Birth Defects
__High Blood Pressure
__Thyroid Disease
__Gallbladder Disease
__Neurological Problems
__Bleeding Disorders
__Blood Clots
__Kidney Disease
__Allergies
__Asthma
__Glaucoma
__Anemia
__Migraines
__Musculoskeletal Disorders
__Osteoporosis
__Infectious Diseases
__Mental Illness
__Gout
__Arthritis
__Autoimmune Disorders
__Other

Social History

Marital Status _____ How Long _____ Children _____ Do you feel safe in your current relationship? _____
☐ Alcohol? How Much? _____ ☐ Caffeine? What kind and how much? _____
☐ Smoking? How Long and Often? _____ ☐ Recreational Drugs? What and how often? _____
☐ Exercise? What kind? _____ ☐ Travel outside of the U.S.? Where and when? _____

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Medical History Continued

Surgical and Hospitalization History – Dates -- Reasons

☐ None

☐ _____

_____

Past Medical History: Please indicate if you have had any of the following in the past.

☐ None

__ADD/ADHA
__AIDS/HIV
__Abuse/Domestic Violence
__Acid Reflux (GERD)
__Acne
__Allergies
__Anemia
__Anesthesia Complications
__Anxiety Disorder
__Arthritis
__Asthma
__Autism Spectrum Disorder (ASD)
__Autoimmune Disease
__Bi-polar
__Birth Defects or Inherited Disease
__Bladder or Kidney Problems
__Blood Disease
__Blood Transfusion
__Born by Cesarean Section
__Breast Cancer
__Breast Problem
__COPD
__Cancer, type? _____
__Chicken Pox
__Chronic Ear Infections
__Congestive Heart Failure (CHF)
__Constipation
__Depression
__Postpartum Depression
__Dermatologic Disorders
__Developmental or Behavioral Disorders
__Diabetes
__Difficulty Swallowing
__Diverticulitis
__Drug/Latex Reactions
__Ear or Hearing Problems
__Eating Disorder
__Eczema
__Endometriosis
__Fibromyalgia
__GI Problems
__Gout
__Headaches
__Heart Disease
__Heart Problems
__Hematologic Disorder
__High Cholesterol
__History of STD
__History of Abnormal Pap
__Hospitalizations
__Hypertension
__Hyperthyroidism
__Hypothyroidism
__Infection, type? _____
__Infertility
__Kidney Disease
__Kidney Stones
__Liver Disease
__Lung Disease
__MRSA exposure
__Meniere's Disease
__Mental Illness
__Muscle, Joint, or Bone Problems
__Neurologic/Epilepsy
__Obesity
__Osteoporosis
__Polycystic Ovary Syndrome
__Polyps
__Pulmonary Embolism
__Seizures/Epilepsy
__Skin Problems
__Stroke
__Thrombophilia
__Thyroid Problems
__Trauma/Violence
__Tuberculosis
__Urinary Tract Infection
__Varicosities
__Vision or Eye Problems
__Other _____

Menstrual History: Females

LMP _____ LNMP _____ Cycle Length _____ Pain/Excessive Bleeding? _____
Last Pap _____ Abnormal Pap? _____ Last Mammogram _____ Abnormal Mammogram? _____
Past Pregnancies: Number _____ Term _____ Preterm _____ Stillbirth _____ Miscarriages _____ Abortions _____
Contraception? _____ Currently Sexually Active? _____
History of STD? _____ Pre-eclampsia? _____ Gestational Diabetes? _____

Prostate History: Male

Last Prostate Exam _____ Any Abnormalities _____

Aurora Family Health & Maternity Care Services, LLC

Review of Systems

Name	Birth Date / /	Who are you seeing today?	Today's Date / /

Do you have any specific goals or questions that you would like to discuss with your provider today?

Please list any changes to your supplements or medications:

Please list any **demographic changes** (phone, address, insurance):

Please Check Any Symptoms You Have Experienced In The Past Two Weeks

Constitutional

☐ No Complaints ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss ☐ Exercise Intolerance ☐ Chills ☐ Fatigue/Malaise
☐ Other_____

Eyes

☐ No Complaints ☐ Dry Eyes ☐ Vision Changes ☐ Irritation ☐ Eye Disease/Injury ☐ Wears Glasses/Contacts
☐ Other_____

Ears/Nose/Mouth/Throat

Ears: ☐ No Complaints ☐ Difficulty Hearing ☐ Ear Pain ☐ Ringing in the Ears ☐ Other_____
Nose: ☐ No Complaints ☐ Frequent Nosebleeds ☐ Nose Problems ☐ Sinus Problems ☐ Sinusitis ☐ Other_____
Mouth/Throat: ☐ No Complaints ☐ Sore Throat ☐ Bleeding Gums ☐ Snoring ☐ Dry Mouth ☐ Mouth Ulcers ☐ Oral Abnormalities ☐ Teeth Problems ☐ Other_____

Cardiovascular

☐ No Complaints ☐ Chest Pain ☐ Arm Pain on Exertion ☐ Shortness of Breath When Walking ☐ Shortness of Breath when Lying Down ☐ Palpitations ☐ Known Heart Murmur ☐ Ankle Swelling ☐ Other_____

Respiratory

☐ No Complaints ☐ Cough ☐ Wheezing ☐ Shortness of Breath ☐ Coughing Up Blood ☐ Sleep Apnea ☐ Other_____

Gastrointestinal

☐ No Complaints ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Abnormal Appetite ☐ Diarrhea
☐ Dyspepsia/Indigestion ☐ GERD ☐ Other_____