WINDERMERE
Medical Center
Primary Care | Walk-in Care | Chiropractic Care

PATIENT REGISTRATION

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: _____ Date of Birth/Age: _____

Mailing Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Sex: ☐Male ☐Female

Social Security #: _____ - _____ - _____ Email address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Contact Number: _____ Address: _____

Referral Source:

☐ Website/Internet Search _____ ☐ Patient Referral _____

☐ Magazine/Name _____ ☐ Direct Mail _____

☐ Newspaper/Name _____ ☐ Chamber of Commerce _____

INSURANCE

Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder SSN: _____ - _____ - _____ DOB: _____ Relation to Patient: _____

OFFICE USE ONLY

SCANNED PICTURE ID: _____ SCANNED ID/INSURANCE CARD: _____

ALL FORMS REVIEWED BY: _____

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Marketplace/ObamaCare Insurance Financial Policy

The Affordable Care Act (ACA) created the Advance Premium Tax Credit (APTC) to assist patients in paying their health insurance premiums. This tax credit does not subsidize the entire premium, and as such, you are responsible for paying the remainder portion of your health insurance premium.

If you purchased your health insurance through the ObamaCare website (www.healthcare.gov), you are required to make your monthly premium payments to avoid a 90-day grace period, which puts you at risk of losing your coverage if payment is not made in full at the end of the grace period.

According to federal regulation §156.270, your insurance carrier is required to notify us if you have defaulted on your premium payments. If we receive such notification from your insurance carrier, we will send you a statement for the balance due on your account for services rendered at Windermere Medical Center. Your account will be placed in a self-pay status until your premiums payments are made in full (we will call your insurance carrier for confirmation of payment). If your policy is canceled due to non-payment of premiums, your account with Windermere Medical Center will remain in a self-pay status.

If your balance with Windermere Medical Center is not paid in full after 90 days, your account will be forwarded to a collection agency to collect on your account.

By signing this policy below, the patient/parent confirms that:

I understand and acknowledge that I am personally responsible to pay Windermere Medical Center in full for services that my health insurance payer will not cover due to non-payment of my health insurance premiums. I further understand and acknowledge that my account will be placed in a self-pay status, and I am at risk for my account being forwarded to a collection agency if I do not pay my balance in full.

I confirm that I have **not** purchased insurance through ObamaCare (www.healthcare.gov). I have insurance through my employer or another private/commercial or Medicare plan, or I am a self-pay patient.

_____ _____

Patient Name/Signature Date

I confirm that I **have** purchased insurance through ObamaCare at www.healthcare.gov; I will comply with this policy regarding my account.

_____ _____

Patient Name/Signature Date

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CASE HISTORY: _____ DATE: _____

Please answer all questions completely. Please print.

This information is confidential in nature. Your answers will help us determine your course of treatment

Name: _____ Sex: _____ Marital Status: _____ Date of Birth: _____

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

Occupation: _____ Who referred you? _____

Employers Name: _____ Employers Address: _____

Office Phone Number: _____ Home Phone Number: _____ Cell: _____

Primary Insurance Company: _____ Address: _____

Your Social Security Number: _____ Secondary Insurance: _____

Spouse First Name: _____Spouse SS# _____

Spouse's Employer: _____ Spouse work Number: _____

Emergency Contact Person: _____ Phone Number: _____

1. Major Complaints

_____
_____
_____

2. Date current symptoms began? _____ What caused symptoms? _____
_____

3. Pain is now ___ mild ___ moderate ___severe ___improving ___staying the same ___ worse

4. Has this happened before? ___ Yes ___ No If yes, when_____

5. Does this interfere with normal daily activity? ___ Yes ___ No Family history of same condition?___ Yes___ No

6. What helps this condition? _____

7. What aggravates this condition? _____

8. Any work related accidents in the past two years? ___ Yes ___ No

9. Any automobile accidents in the past two years? ___ Yes ___ No

10. Do you smoke? _____ Are you taking any nutritional supplements? ___ Yes ___ No

11. Have you been treated for this condition by another doctor? ___ Yes ___ No

12. If yes, What doctor: _____

13. What treatment by other doctor? _____ Length of care? _____

14. What was your diagnosis? _____ Were x-rays taken? ___ Yes ___ No

15. List any surgeries: _____

16. List any Fractures: ___ Yes ___ No Medications taking: _____

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Name: _____ Date: _____

Please indicate for each of the following questions below your experience by use of the following codes:
(1) Never Had (2) Previously Had (3) Presently Have

Musculoskeletal System

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Sore muscles
_____ Weak muscles
_____ Walking problems
_____ Ruptures
_____ Broken bones

Genito-Uniary System

_____ Bladder trouble
_____ Excessive urination
_____ Scanty urination
_____ Painful urination
_____ Discolored urine

FEMALE

_____ Vaginal discharge
_____ Vaginal bleeding
_____ Vaginal pain
_____ Breast pain
_____ Lumps on breast

Are your Pregnant?
___ Yes ___ No

Gastro-Intestinal System

_____ Poor appetite
_____ Excessive hunger
_____ Difficult swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting blood
_____ Abdominal pain
_____ Diarrhea
_____ Constipation
_____ Black stools
_____ Gall bladder problems
_____ Bloody stools
_____ Weight problems

Cardiovascular System

_____ Chest pain
_____ Pain over heart
_____ Difficult breathing
_____ Persistent cough
_____ Coughing phlegm
_____ Coughing blood
_____ Rapid heartbeat
_____ High blood pressure
_____ Heart problems
_____ Lung problems
_____ Varicose veins

Eye, Ear, Nose & Throat

_____ Eye strain
_____ Eye Inflammation
_____ Vision problems
_____ Ear pain
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Nose pain
_____ Difficult breathing through nose
_____ Sore / mouth or gums
_____ Sore throat / Difficult speaking

Nervous System

_____ Numbness
_____ Loss of feeling
_____ Paralysis
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Muscle jerking
_____ Convulsions
_____ Forgetfulness
_____ Confusion
_____ Depression

Patient Signature: _____ Date: _____