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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Adult Health History Form

_____ _____
Name DOB

Medical History (*Please check here if no past/current medical history:* ☐)

Now	Past	Common Conditions
		Alcohol / Drug abuse
		Allergy (seasonal)
		Anemia
		Anxiety
		Arthritis
		Asthma
		Bladder / Kidney Problems
		Blood Clot (leg)
		Blood Clot (lung)
		Blood Transfusion
		Breast Lump (benign)
		Cancer _____
		Cataracts
		Colon Polyp
		Coronary Artery Disease
		Depression
		Diabetes Type I/Type II
		Diverticulosis
		Emphysema (COPD)
		GERD (Heartburn/Reflux)
		Glaucoma
		Gout
		Gyn conditions (fibroid/PCOS)
		Heart Attack
		Hepatitis B or C

Now	Past	Common Conditions
		High Blood Pressure
		High Cholesterol
		Hyperthyroidism
		Hypothyroidism
		Irritable Bowel Syndrome
		Kidney Disease / Failure
		Kidney Stones
		Liver Disease
		Migraine Headaches
		Osteoporosis
		Prostate (enlargement)
		Prostate (nodules)
		Rheumatoid Arthritis
		Seizure / Epilepsy
		Sinusitis (chronic)
		Skin Condition _____
		Sleep Apnea
		Stomach Ulcer
		Stroke/TIA
		Thyroid Nodule
		Other _____
		Other _____
		Other _____
		Other _____
		Other _____

Surgical History
(*Please check here if no surgical history:* ☐)

	Abdominal surgery		Coronary bypass		Hip Surgery		Thyroidectomy
	Appendix removal		Coronary Stent		Hysterectomy (partial)		Tonsillectomy
	Back surgery		C-Section		Hysterectomy (total)		Tubal ligation
	Biopsy _____		Endoscopy		Knee Surgery		Wisdom Teeth
	Breast Biopsy		Gallbladder Removal		LEEP		Vasectomy
	Breast surgery		Gastric Bypass		Neck surgery		Other _____
	Broken Bone		Laparoscopic		Ovary Removal		Other _____
	Cataract surgery		Heart Surgery		Sinus Surgery		Other _____

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Adult Health History Form

Please check here if you are not taking any medications: □

Medication Name	Dose (mg)	How many times per day?

Social History

1. Occupation _____Employer: _____

   □Retired □Homemaker □Student □Unemployed

2. Who lives with you? □Spouse/Partner □Children □Roommates □Parents □Other

3. Tobacco use (including cigars): □Current every day □Current some day □Former Smoker □Never used

4. Alcohol use (beer/wine/liquor): □1-3 □4-6 □7+ per □Day □Week □Month □Year □No alcohol use

Females

Date of last menstruation: _____ Are you breastfeeding or pregnant? Yes _____ No _____

Family History

Father (Living/Deceased): Please circle: High blood pressure / Diabetes /Cancer _____ / Stroke / Other_____

Mother (Living/Deceased): Please circle: High blood pressure / Diabetes /Cancer _____ / Stroke / Other_____

Other significant family history: _____

Medication allergies: _____

Preferred pharmacy: _____