www.JacksonHealth.org
305-585-1111

Jackson HEALTH SYSTEM PUBLIC HEALTH TRUST

Public Health Screening

Have you traveled to or from any of the following countries within the past 31 days: Guinea, Liberia, Sierra Leone, or Democratic Republic of Congo AND do you have a fever, headache, muscle pain, vomiting, diarrhea, abdominal pain or unexplained bleeding or other symptoms?

Yes No

Have you recently come into contact with anyone who has traveled to or from the above countries and who has any of those symptoms?

Yes No

Have you had any contact with animals (bats, rodents, monkeys) from the above countries?

Yes No

If you have selected "Yes" to any of the above, you meet the criteria for travel exposure. We will escort you to a private room for further testing. A staff member will meet with you promptly to explain the next steps and answer any questions.

Patient Name (please print): _____

Parent or Guardian Name (for patients under 18 years old): _____

Signature: _____

Date: _____

Jackson Medical Group
JACKSON HEALTH SYSTEM

PATIENT REGISTRATION FORM

PATIENT INFORMATION

(Title) _____ Patient Name (Last) _____ (First) _____ (MI) ___

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Date of Birth: MM _____/DD _____/YYYY _____ Age: _____ SSN: _____-_____-_____

Sex: ☐ Female ☐ Male ☐ Transgender

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

Race: ☐ White ☐ African American ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Declined

Language: ☐ English ☐ Spanish ☐ Creole ☐ Other _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

Employment Status: *(select all that apply)* ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Full-Time Student ☐ Part-Time Student

Employer Name _____ Work Phone _____

Emergency Contact _____ Phone Number _____

Relationship to Patient _____

Do you have a living will? ☐ Yes ☐ No

Primary Care Provider (PCP) _____ Referring Provider _____

PCP Phone #: _____ Ref. Provider Phone # _____

Rendering Provider Name (Physician at this practice) _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Self ☐ Guarantor ☐ **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor SSN: _____-_____-_____ Guarantor Date of Birth: MM ____/ DD___ /YYYY_____

Sex: ☐ Female ☐ Male ☐ Transgender

E-Mail Address _____

Address Line _____

City _____ State _____ Zip Code _____ Primary Phone _____

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PRIMARY INSURANCE INFORMATION

(Provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Insured Date of Birth: MM ____/ DD___ /YYYY_____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone Number _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Insured Date of Birth: MM ____/ DD___ /YYYY_____

FINANCIAL POLICY

The doctors and the healthcare providers of Jackson Medical Group (JMG) charge fees for the care provided to me. The fees may not be exactly the same as the estimate given.

I know that my health insurance company may not pay the full amount of the fees charged by JMG. This means I may have to pay JMG for the cost of care that is not paid by my health insurance company.

If I have not given JMG the right health insurance information, then I may have to pay the fees for my care.

If I do not have health insurance, then I will have to pay the fees for my care.

Medicare will only pay for the care that is acceptable and needed under section 19862(a)(1) of the Medicare Law. The facts I have given to JMG for payment under Tittle XVIII and XIX of the Social Security Act are correct.

JMG can bill my health insurance company for my care. Payments will be made to JMG on my behalf.

SOCIAL SECURITY NUMBER

I voluntarily give Jackson Medical Group my social security number if needed to identify me and file charges with my insurance company. JMG will follow any federal and state laws about the use and protection of my Social Security Number.

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient** (or Responsible Party) **Signature _____ ***Date*** _____

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PATIENT HIPAA ACKNOWLEDEMENT

Patient Name: _____ **Date of Birth:**_____

_____ (patient initials) **Notice of Privacy Practice.** I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (patient initials) **Release of Information.** I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for the purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at a facility owned or managed by Jackson Health System, an agent of the Public Health Trust, may be made available to subsequent JHS admitting facilities to coordinate patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage of payment, answer payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim. This information may include without limitation, history and physical, emergency records, laboratory reports, physician progress notes, operative reports, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improvement of the accuracy and availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations.

DISCLOSURE TO FRIENDS AND/OR FAMILY MEMBERS

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below.

Name	Relationship	Phone Number
1.		
2.		
3.		

Jackson
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JACKSON HEALTH SYSTEM

CONSENT TO TREATMENT

I am a patient of Jackson Medical Group. By signing this form, I give my consent to be treated by the doctors of this practice.

My doctor needs medical facts about my health. I, _____, ask for and allow the doctors and staff of Jackson Medical Group to give me the needed medical treatment and services they recommend.

I understand treatment and services may include:

- Lab tests
- Screening tests (tests that can find an illness early, before a person shows signs of having the disease)
- Diagnostic tests (tests that shows if a person has a certain illness or health problem)
- Routine exams

I understand that no promises have been made to me about the results of any treatment or services.

I acknowledge that I have read and understood each of the above provisions appearing on this page. I have also had the opportunity to ask any questions, and by my signature, I consent and agree to such provisions individually and collectively. A copy may be used in lieu of the original.

Patient or Guardian Signature_____ **Date** _____

CONSENT TO EMAIL OR PHONE FOR HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email from the practice.

May we contact you via email? ☐ Yes ☐ No

Email Address _____

May we leave a voice message on the telephone answering machine with our name and telephone number?

☐ Yes ☐ No

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTHCARE OPERATIONS

_____ (patient initials) I consent to photographs, video, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's healthcare operations purposes (for example, quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I am allowed to request copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written consent from me or my legal representative unless for treatment, payment or healthcare operations purposes or otherwise permitted or required by law.

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PHARMACY INFORMATION

Pharmacy Name _____ **Phone Number** _____

_____ (patient initials) **Pharmacy Consent.** I give the Jackson Medical Group authorization to obtain my prescription records from participating pharmacies.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick-up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to be present valid picture identification and sign for the prescription.

_____ (patient initials) I wish to designate the following member/friend to pick up an order on my behalf.

Designee Name _____

_____ (patient initials) I do not want to designate anyone to pick up my prescription order.

Patient Signature _____ **Date** _____

Jackson Medical Group

Authorization for Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

I,_____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction.

1. Release Information From:	Release Information To:
☐ JMG Specialty Physicians: _____ _____ _____	☐ JMG Specialty Physicians: _____ _____ _____
☐ Other: (specify facility/individual) and address below, including phone/fax) _____ _____ _____	☐ Other: (specify facility/individual) and address below, including phone/fax) _____ _____ _____

2. Specific description of the protected health information that I authorize for disclosure:
   ☐ Treatment notes ☐ diagnostic test results ☐ history/physical notes ☐ All
   ☐ Operative reports ☐ billing data. Other: _____

3. Specific description of the purpose for each use or disclosure:
   Medical Treatment

4. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

5. I understand the information released may include information that may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome("AIDS"). Initial:
   _____

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signature: _____ Date: _____

Name: _____ Relationship or Authority of Personal Representative (if applicable): _____

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PATIENT INTAKE HISTORY

Patient Name _____ Date_____

DOB: _____ Referring Physician: _____

Reason for Today's Visit _____

ALLERGIES TO MEDICATIONS OR OTHER ALLERGIES- IF NONE, CHECK HERE ☐

Allergy	Type of Reaction

CURRENT MEDICATION- IF NONE, CHECK HERE ☐

(Medications include hormones, vitamins, herbs and non-prescription medications)

Current Medication	Dosage	Who prescribed this medication?

PAST HISTORY OF ILLNESS

Have you ever been diagnosed with any major health problem listed below?

Major Illness	YES (Date)	NO	NOTES
Cancer			Type:
Heart and Blood Vessels: Atrial Fibrillation			
Stroke			
TIA			
Congestive Heart Failure			
Coronary Artery Disease			
Elevated Blood Cholesterol			
Heart Attack			

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Patient Name_____Date of Birth_____

Heart Disease			
Irregular heart rate **Major Illness**	**YES (Date)**	**NO**	**NOTES**
Peripheral vascular disease			
Prostate Enlargement			(Males only)
Renal Insufficiency			
Alcohol or drug treatment			
Chronic Anxiety			
Depression			
Diabetes			Type:
Thyroid disease			Type:
Asthma			
COPD			
Emphysema			
Hemophilia			
Anemia			
Bleeding Disorder			
Stomach Ulcer			
Reflux			
Hepatitis			Type:

If you are a female, please answer the questions listed below.

For Women Only:	**YES**	**NO**	**NOTES**
Are you pregnant?			
If yes, which trimester?			1st ____ 2nd ____ 3rd ____
Number of Pregnancies	-	-	Total Pregnancies:
Do you have a normal menstrual period?			
Last Menstrual Period	-	-	Date:
Menstrual Cycle Age Onset	-	-	Age:

SURGERIES/HOSPITALIZATIONS- IF NONE, CHECK HERE ☐

Surgery/Reason	Date/Year	Hospital Where Performed

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Patient Name	Date of Birth

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Cause:	Father: ☐ Living ☐ Deceased Cause:

Siblings:	Number Living:	Number Deceased: Cause(s):
Children:	Number Living:	Number Deceased: Cause(s):

FAMILY ILLNESS	YES	WHICH RELATIVE?	PHYSICIAN NOTES:
Diabetes			
Stroke			
Heart Disease			
High Blood Pressure			
Lung Cancer			
Asthma			
Breast Cancer			
Skin Cancer			
Colon Cancer			
Cholesterol			
Dementia			
Bleeding/clotting problem			
Other:			
Other:			
Other:			

SOCIAL HISTORY

	PHYSICIAN NOTES:
☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Occupation/Job:	
Have you ever smoked? ☐ Yes ☐ No	
If you are currently smoking, are you ready to quit? ☐ Yes ☐ No	
Alcohol- Drinks Per Week: _____ Drinks Per Month: _____	
Caffeine Use- ☐ None _____ Cups/Day	