Complete Care Medicine
Registration/Update Form

Today's Date: _____

Patient Information

Patient's Name: _____ (Last) _____ (First) _____ (MI) _____ (Date of Birth) Male ◯ Female ◯

_____ (Age) _____ (Social Security Number)

Race: American Indian ☐ Black or African American ☐ Native Hawaiian ☐ White ☐ Other ☐

Ethnicity: Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

_____ (Home Phone) _____ (Work Phone) _____ (Mobile Phone) _____ (E-mail Address)

Preferred Method of Contact: Phone ☐ E-mail ☐ USPS ☐

Employment Information: _____ (Occupation) _____ (Employer's Name)

Employer Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Health Insurance Information

PRIMARY INSURANCE

Name of Insurance Plan _____

Insurance Identification Number _____

Group No. or Name of Employer _____

Date Insurance Began _____

HMO ☐ PPO ☐ Other ☐

Co-pay Amount _____

Name of Person Who Carries Insurance _____

_____ (Date of Birth) _____ (Social Security Number)

SECONDARY INSURANCE

Name of Insurance Plan _____

Insurance Identification Number _____

Group No. or Name of Employer _____

Date Insurance Began _____

HMO ☐ PPO ☐ Other ☐

Co-pay Amount _____

Name of Person Who Carries Insurance _____

_____ (Date of Birth) _____ (Social Security Number)

***Preferred Pharmacy:** Name _____ Cross Streets _____

PLEASE COMPLETE FOR: (SPOUSE IF MARRIED) OR (PARENT IF A DEPENDENT)

Name: _____ (Last) _____ (First) _____ (MI) _____ (Relationship to Patient) _____ (Social Security Number)

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

_____ (Date of Birth) _____ (Home Phone) _____ (Work Phone) _____ (Mobile Phone)

_____ (Occupation) _____ (Employer's Name)

Employer Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

IN CASE OF URGENT NEED, PLEASE CONTACT THE FOLLOWING PERSON

Name _____ Home Phone _____ Relationship to Patient _____

COMPLETE CARE MEDICINE
Adult Medical History Form

Name _____ **Age** _____ **Date** _____

Occupation _____ **Date of Last Physical** _____

Please list all the medications, including over the counter medications that you are taking or have recently been taking.

Medication	Dose/Frequency	Discontinued	Medication	Dose/Frequency	Discontinued

Please list any allergies to food or medication you may have:

Allergy:_____What happens:_____
Allergy:_____What happens:_____
Allergy:_____What happens:_____

Have you had: A tetanus shot within the last 10 years? ☐**YES** ☐**NO** A flu shot? ☐**YES** ☐**NO** All childhood immunizations? ☐**YES** ☐**NO**

Other Vaccines: _____

Please list all any Medical conditions for which you have been diagnosed (i.e. Diabetes, High Cholesterol, Hypertension, etc..)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Please list all any Surgeries that you have undergone (Please include the approximate month/year)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Social History:

Do you smoke or use any tobacco products? ☐**YES** ☐**NO** Do you use alcohol products? ☐**YES** ☐**NO** Do you use recreational drugs? ☐**YES** ☐**NO**

Family History

Is there a history of: (check all that apply)

	Mother	Father	Grandparents	Siblings	Other
Stroke					
Diabetes					
Hypertension					
Heart Attack					
Glaucoma					
Asthma/Emphysema					
Depression					
Other Diseases					

Do you have an Advanced Directive? ☐**Yes** ☐**No**
Would you like more information about Advanced Directives? ☐**Yes** ☐**No**

This Section for Women Only

What form of contraception do you and your partner use? _____
When was your last pap test? _____ Was it normal? ☐**Yes** ☐**No** _____
When was your last mammogram?_____ Was it normal? ☐**Yes** ☐**No** _____

This Section for Men Only

What form of contraception do you and your partner use? _____

Patient/Guardian Signature:_____ Date:_____

By signing this form, I acknowledge that I have read and understand Complete Care Medicine's office policies.

Patient Name: _____ Date of Birth: _____

Print Name: _____ Date: _____

Relation to Patient (Circle): Self Mother Father Spouse Other: _____

Signature: _____

1489 S. Higley Road, Suite 101
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Complete Care Medicine

Privacy Practice Acknowledgement and Family Auth

Patient Information (Please Print):

Name:_____ Date of Birth: _____

Phone:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under HIPAA requirements, we are not allowed to release this information without the patient's consent. If you would like us to release billing or medical information to family members you must sign this form. Only the family members listed below **CAN** have access to your records.

1._____ Relationship to Patient: _____

2._____ Relationship to Patient: _____

3._____ Relationship to Patient: _____

Please list any family members that you **DO NOT** want CCM to discuss your medical or billing information with:

1._____

2._____

Complete Care Medicine is authorized to: (Please check appropriate boxes below.)

- ☐ Call my home phone number
- ☐ Call my cell phone number
- ☐ Call my work phone number
- ☐ Leave a message on my home phone number
- ☐ Leave a message on my cell phone number
- ☐ Leave a message on my work phone number

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in the Notice of Privacy Practices. I am aware that I may request a copy of the Notice of Privacy Practices for Complete Care Medicine and one will be provided to me. I understand that I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. **I understand that this authorization will remain in effect indefinitely unless revoked in writing by the patient or legal representative.**

Patient's Signature _____ Date _____

Parent/Legal Representative Signature/Relationship To Pt _____ Date _____

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Complete Care Medicine

Authorization For Release of Medical Records

Patient Information (Please Print):

Name:_____ Date of Birth: _____

Social Security Number:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone:_____

Release Information **From**:

☐ Name_____
Address:_____
City:_____ State: _____ Zip Code: _____
Phone: _____ Fax:_____

Release Information **To:**

☐ Name_____
Address:_____
City:_____ State: _____ Zip Code: _____
Phone: _____ Fax:_____

Information to Be Released:

☐ Entire Medical Record, **including** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Entire Medical Record, **excluding** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS

☐ Past _____Years

☐ Lab Results

☐ Imaging Results

Other: (Please be as specific as possible, including any information you **DO NOT** want released) _____

☐ _____
_____
_____

Reason for Release:

☐ Personal Copy

☐ Continuation Of Care (Specialist)

☐ Legal

☐ Changing Primary Care Doctors

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in this document. I understand that this authorization is valid for 1 year unless otherwise specified and I have the right to revoke this authorization at any time by providing a written statement to Complete Care Medicine where the authorization was originally submitted, except to the extent that CCM has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Patient's Signature _____ Date _____

Parent/Legal Representative Signature/Relationship To Pt _____ Date _____