Southwest Medical®
Part of OptumCare®

New Patient Registration and Questionnaire

Section 1

Patient Information			
Name:			MRN:
AKA:			Sex: ☐ M ☐ F
Birth Date:		Marital Status:	Preferred Method of Contact:
Email Address:			☐ Mail ☐ Phone
Address 1:		Home Phone:	
Address 2:		Mobile:	
City, State:		Zip:	

Person Responsible for Bill – Guarantor Information	
Guarantor Name:	
Relation to Guarantor: ☐ Parent ☐ Sibling ☐ Child ☐ Aunt/Uncle ☐ Legal Guardian ☐ Other	
Address:	Telephone #:
City, State:	Zip:

Patient Employer Information		Guarantor Employer Information	
Employer:		Employer:	
Address 1:		Address 1:	
Address 2:	Telephone #	Address 2:	Telephone #:
City, State:	Zip:	City, State:	Zip:

Emergency Contact Information	
Name:	Relation:
Address:	
City, State:	Zip:
Home Telephone #:	Mobile #:

Insurance Information		
Primary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Secondary Insurance:	Subscriber Name:	DOB:
	ID Number:	
Tertiary Insurance:	Subscriber Name:	DOB:
	ID Number:	

New Patient Registration and Questionnaire

1. Demographic

Race	Ethnicity
☐ White ☐ African American/Black ☐ American Indian ☐ Asian/Pacific Islander ☐ Other ☐ Decline ☐ Unknown	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Unknown
Do you need a translator? ☐ Y ☐ N	Primary spoken language:
Do you have an Advance Directive? ☐ Y ☐ N	Are you hearing impaired? ☐ Y ☐ N

2. Health Maintenance

a. When was the last time you had the following tests performed? (please check all that apply)

	Past Year	2 Years	10 years	Never
Colonoscopy				
Routine Physical				
Eye Exam				
Breathing Test				
Bone Density				
Cholesterol Check				
Flu Shot				
Pneumonia Vaccine				
Women's Health				
Mammogram				
PAP Smear				

3. Past Medical History

a. Do you have or have you ever been diagnosed with: (If yes, please specify how long ago)

	Yes	No	0 – 12 months	1 – 3 years	3 - 5 years	5 – 10 years	10+ years
Diabetes							
High Blood Pressure							
Heart Disease							
High Cholesterol							
Cancer							
Stroke							
Seizures							
Lung Disease (Asthma, COPD, etc.)							
Glaucoma							
HIV							
Other(s):							

b. Have you been hospitalized in the past year? ☐ Y ☐ N (If yes, please specify below)

Date	Hospital	Reason

For additional space, please use page 5 addendum 3b

c. Do you see any specialists? ☐ Y ☐ N If yes, please provide the name and reason:

Specialist Name	Reason

For additional space, please use page 5 addendum 3c

4. Past Surgical History

Have you ever had surgery? ☐ Y ☐ N If Yes, please explain:

Date	Procedure	Reason

For additional space, please use page 5 addendum 4

5. Family History

	Yes	No	Relation (e.g. father)
Diabetes			
High Blood Pressure (Hypertension)			
Heart Disease			
High Cholesterol			
Cancer			
Stroke			
Seizures			
Lung Disease (Asthma, COPD, etc.)			
Other(s):			

6. Social History

a. What is your smoking status? Never_____Past Smoker_____Current Smoker_____

How many packs per day?_____How many years of smoking history? _____

b. Do you drink alcoholic beverages? ☐ Y ☐ N If yes, approx. # drinks per week: _____

c. Have you or do you use any drugs for recreational use (confidential): ☐ Y ☐ N

If yes, please explain: _____

Have you been exposed to any conditions/events that could potentially be damaging to your health (i.e. military combat, occupational hazards, etc.)? If yes, please explain: _____

_____

_____

7. Allergies

Do you have any food or drug allergies? ☐ Y ☐ N If yes, please list and describe:

Food or Drug	Reaction

For additional space, please use page 5 addendum 7

8. Medications

Please list all medications, including over the counter "OTC" medications and herbal supplements that you are currently taking or have taken in the last 12 months:

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

For additional space, please use page 5 addendum 8

9. Pharmacy Information

Please provide us with the name and location of your preferred pharmacy:

Name:_____Phone:_____

Location:_____

10. Patient/Provider Review

Please sign below to confirm that the information above is accurate and has been reviewed.

Patient Signature:_____ Date:_____

Provider Signature:_____ Date: _____

Addendum

3.b Past Hospitalizations

Date	Hospital	Reason

3.c Current Specialists

Specialist Name	Reason

4. Past Surgical History

Date	Procedure	Reason

7. Allergies

Food or Drug	Reaction

8. Medications

Drug, OTC, or Herbal Supplement	Currently Taking?		Dose	Treatment Purpose
	Yes	No		

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-866-763-0044. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-763-0044.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電： 1-866-763-0044.

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Patient Name:

MRN:

DOB:

Patient Communication Opt-in

☐ **Opt-in for E-mail, Phone Calls and Text**

E-mail address:_____ **Cell phone number:**_____

By providing your email address and phone number, you agree to:

- receive emails from Southwest Medical, and its affiliates, regarding topics such as news, events, available services, appointment reminders, and prescription renewal reminders. You acknowledge that if these emails contain your protected health information, the emails will be sent unencrypted and there is a risk of interception or disclosure of the contents of the emails.
- receive SMS alerts and notifications related to news, events, available services, appointment reminders and prescription renewal reminders on your phone
- receive phone calls regarding appointment reminders, test results, RX renewals, marketing, and outreach
- Message and data rates may apply;
- Terms and privacy information are available at; smalv.com/en/texting-terms-conditions
- Messages will be recurring; and
- You acknowledge and agree that these text messages, which may contain Protected Health Information (PHI), will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Your signature acknowledges that you understand the terms of receiving non-secure emails, phone calls and/or texts, based on your preference, from Southwest Medical, and its affiliates, and you can opt-out of communications at any time by calling us at 702-877-5199.

_____ _____

Print Name Patient Signature

_____

Date

Patient Name:

MRN:

DOB:

Authorized Individual Account Opt-In Adult Patient Portal Records

I, _____ grant authorized individual access to, _____,
Patient Name Printed Patient Representative Name

with the understanding that this allows direct access to actions related to my healthcare on my behalf and view PHI contained in my electronic health records via secure patient portal. This connection can be severed by request at any time should I want to revoke authorized individual access.

_____ _____
Personal Representative Email Patient Signature

_____
Date

Authorized Individual Account Opt-In for Adolescent Patient Portal Records (minors over 12 years)

By providing an email address for a minor child's personal representative, the minor child consents to

- granting their personal representative access to their electronic health records via secure patient portal on their behalf.
- allow proxy access to the minor child's account and disclose PHI access to the authorized individual selected.
- allow direct access to actions related to the minor child's healthcare on their behalf. This connection can be severed by at the patient's request at any time, should the minor patient want to revoke authorized individual access.

_____ _____
Personal Representative Email Patient Signature

_____
Date