Quality Health Care, Inc.

Laurence Lum, D.C., President / C.E.O.

330 N. State St., Suite C • Desloge, Missouri 63601

Phone: 573-431-4449 • Fax: 573-431-2443

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Phone: 573-431-2829
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Debbie A. Anderson, FNP
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PATIENT REGISTRATION

Name of Patient: _____ Sex: ____ Race: _____ Birthdate: _____ Home Phone: _____
FIRST MIDDLE LAST

Address: _____ City: _____ State: _____ Zip: _____ Cell Phone: _____

Social Security Number; _____ Employer: _____ Marital Status: _____

Employer's Address: _____ Work Phone: _____

Occupation: _____ Email: _____ Referred by: _____

Primary Care Provider: ☐ Dr. Laurence Lum ☐ Kimberly Yeager, FNP ☐ Alicia Whitwell, FNP ☐ Debbie Anderson, FNP

SPOUSE/PARENT/GUARDIAN

Name: _____

Relationship: _____ SS#: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

Employer: _____

Employer's Address: _____

_____

Phone: _____

PRIMARY INSURANCE

Insurance Company: _____

Policy / ID Number: _____

Subscriber Name: _____

DOB: _____

Employer: _____

Group Name: _____

Address for Claims: _____

_____

Relationship: _____ SS#: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

THAT DOES NOT LIVE WITH YOU

Please name family members we can contact by phone/in person regarding health care information &/or especially in case of emergency.

Name: _____

Relationship: _____

Phone: _____ Work # _____

Address: _____

_____

Name: _____ Phone # _____

Name: _____ Phone # _____

SECONDARY INSURANCE

Insurance Company: _____

Policy / ID Number: _____

Subscriber Name: _____

DOB: _____

Employer: _____

Group Name: _____

Address for Claims: _____

_____

Relationship: _____ SS#: _____

Please check yes/no if you have had the COVID vaccination. ___Yes ___No

If yes, what was the date & name of vaccination: _____

Please be advised to sign advanced directives. ___Yes ___No

I AUTHORIZE THE USE AND DISCLOSURE OF ANY PROTECTED HEALTH INFORMATION NECESSARY TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS NEEDED TO PROVIDE ME WITH GOOD HEALTH CARE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW QUALITY HEALTH CARE, INC'S PRIVACY NOTICE AND MAY REQUEST RESTRICTIONS OR REVOKE THIS CONSENT AT ANY TIME. I REQUEST THAT PAYMENT OF BENEFITS BE MADE DIRECTLY TO QUALITY HEALTH CARE, INC. FOR THE REASONS OF CLAIM FORM, AND IF NOT PAID FOR REASONS OF INELIGIBILITY OR NON-COVERED SERVICES, I AGREE TO BE FULLY RESPONSIBLE FOR CHARGES INCURRED.

PATIENT'S FULL NAME _____ DATE OF BIRTH: _____

DRUG ALLERGIES

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S FATHER	FATHER'S MOTHER	MOTHER'S FATHER	MOTHER'S MOTHER	SIBILINGS
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Arthritis/Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Epilepsy/convulsions	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

PATIENT MEDICAL HISTORY

- ☐ Allergies/hay fever _____
- ☐ Alzheimers _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Birth Defects _____
- ☐ Bleeding disorder _____
- ☐ Blood clots _____
- ☐ Bowel irregularity _____
- ☐ Bronchitis _____
- ☐ Cancer _____
- ☐ Chest pain _____
- ☐ COVID-19 (date, if positive)_____
- ☐ Dementia _____
- ☐ Dementia _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Diptheria _____
- ☐ Dizziness/fainting _____
- ☐ Epilepsy/seizures _____
- ☐ Frequent infections _____
- ☐ Gallbladder disease _____
- ☐ GI disorder _____
- ☐ Gout _____
- ☐ Headache _____
- ☐ Hearing _____
- ☐ Heart attack _____
- ☐ Heart disease _____
- ☐ Heart murmur _____
- ☐ Heart palpitations _____
- ☐ Hepatitis _____
- ☐ High Blood Pressure _____
- ☐ HIV _____
- ☐ Incontinence _____
- ☐ Kidney disease _____
- ☐ Lactose intolerance _____
- ☐ Liver Problems _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Nervousness _____
- ☐ Osteoporosis _____
- ☐ Peripheral vascular disease _____
- ☐ Pneumonia _____
- ☐ Polio _____
- ☐ Prostate disease _____
- ☐ Rheumatic fever _____
- ☐ Rubella _____
- ☐ Scarlet Fever _____
- ☐ Sexual/menstrual dysfunction ____
- ☐ Shortness of breath _____
- ☐ Speech _____
- ☐ Suicidal tendencies _____
- ☐ Tetanus _____
- ☐ Thyroid disease _____
- ☐ Ulcer _____
- ☐ Venereal disease _____
- ☐ Vision _____
- ☐ Other _____

HABITS

☐ Smoke: Packs daily _____
How long _____
Interested in Stopping? _____
☐ Exercise routine _____
_____

☐ Coffee: Cups daily _____
Other caffeine _____
☐ Alcohol: Type/amount_____
☐ Diet: Salt intake _____
Fat intake _____

☐ Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____

☐ Tattoos _____ ☐ Permanent Make-up _____

☐ Contact with blood or body fluid at work? _____

What Language do you speak?_____ Do you need an interpreter? ☐ Yes ☐ No

Are you fearful of physical or emotional abuse? ☐ Yes ☐ No If yes, please explain: _____

WOMEN: _____

Date of last menstrual cycle: _____

Date of last Pap Smear: _____

Date of last Mammogram: _____

Do you perform regular self-breast exams?: _____

MEN: _____

Date of last prostate exam: _____

Have you had a PSA test: _____

If so, date of last test: _____

SIGNATURE _____ DATE _____ AUTHORIZED SIGNATURE IF PATIENT IS A MINOR _____ RELATIONSHIP TO PATIENT _____ DATE _____

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General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner) and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Employee Witness	Employee Job Title
Signature of Employee Witness	Date

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT

Patient Name _____ Date of Birth _____

I have received QHC Notice of Privacy written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types and uses of disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited by or limited by law.
- A description of other uses and disclosures that will be made only with my written consent and that I may revoke such authorization.
- My individual rights with respect to protected health information and brief description of how I may exercise these rights.
- The right to complain to HIPAA Compliance Officer Donna Thurston (573-431-2829) or Coordinator Lanette Kunz (573-431-2829) if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that QHC is not required to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from QHC upon request.

QHC reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain QHC's current Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by representative) _____

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I _____ give permission for Quality Health Care, Inc. to leave a detailed message regarding my appointments, financial obligations, co-pay amount, insurance and test results or referrals. _____Yes _____No. (If no, the office will leave a message for you to return our call).

Please list three family members or friends that we may give health information to in case of an emergency or illness:

Name_____ Phone Number_____

Address_____

Relationship_____

Name_____ Phone Number_____

Address_____

Relationship_____

Name_____ Phone Number_____

Address_____

Relationship_____

*Do you feel safe within your environment?*_____

*Is there anyone trying to harm you?*_____

Signature _____ Date_____

Witness _____Date_____

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PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ Date_____

Patient Date of Birth_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than 1/2 the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed or hopeless.				
c. Trouble falling/staying asleep, sleeping too much.				
d. Feeling tired or having little energy.				
e. Poor appetite or overeating.				
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching TV.				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

2. If you check off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

___Not difficult at all ___Somewhat Difficult __Very Difficult ___Extremely Difficult

TOTAL SCORE_____