



# Quality Health Care, Inc.

Laurence Lum, D.O., 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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## 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  Tabitha Pinkley, 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

Have you ever had any problems with substance abuse (illegal or prescription) \_\_\_ 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	SIBLINGS
Alcoholism	<input type="checkbox"/>						
Arthritis/Osteoporosis	<input type="checkbox"/>						
Asthma	<input type="checkbox"/>						
Bleeding Disorder	<input type="checkbox"/>						
Cancer	<input type="checkbox"/>						
Diabetes	<input type="checkbox"/>						
Epilepsy/convulsions	<input type="checkbox"/>						
Glaucoma	<input type="checkbox"/>						
Heart Disease	<input type="checkbox"/>						
High Blood Pressure	<input type="checkbox"/>						
Kidney Disease	<input type="checkbox"/>						
Mental Illness	<input type="checkbox"/>						
Stroke	<input type="checkbox"/>						
Thyroid Disease	<input type="checkbox"/>						
Ulcers	<input type="checkbox"/>						

**HOSPITALIZATION OR SURGERY**

REASON	DATE	REASON	DATE

**PATIENT MEDICAL HISTORY**

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

**HABITS**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Smoke: Packs daily _____<br>How long _____<br>Interested in Stopping? _____     | <input type="checkbox"/> Coffee: Cups daily _____<br>Other caffeine _____            | <input type="checkbox"/> Sleep: Difficulty falling asleep _____<br>Continuity disturbances _____<br>Snoring _____<br>Early morning awakening _____<br>Daytime drowsiness _____ |
| <input type="checkbox"/> Exercise routine _____  | <input type="checkbox"/> Alcohol: Type/amount _____                                  |  |
| <input type="checkbox"/> Tattoos _____   | <input type="checkbox"/> Diet: Salt intake _____<br>Fat intake _____                 |  |
| <input type="checkbox"/> Contact with blood or body fluid at work? _____                                 | <input type="checkbox"/> Permanent Make-up _____                                     |  |
| What Language do you speak? _____  | Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Are you fearful of physical or emotional abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, please explain: _____  |  |
| Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No                              |  |  |

- 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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## 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?

	<b>Not at all (0)</b>	<b>Several days (1)</b>	<b>More than 1/2 the days (2)</b>	<b>Nearly every day (3)</b>
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 \_\_\_\_\_



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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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## 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 Crystal Johnson (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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## 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