midwest
MEDICAL CENTER

Registration Form

Last Name: _____ **First Name:**_____ **MI:**____

Address: _____

City:_____ State:_____ Zip:_____

Date of Birth:_____/_____/_____ **SS#**_____-_____-_____ **Age:**_____ **Sex:** _____ M/F

Marital status: Single Married Divorced Separated Widow **Ethnicity:** Hispanic Non Hispanic

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or other Pacific Islander White

Phone: Home:_____ Cell:_____ Work:_____

Email Address:_____

Emergency Contact::

Last Name: _____ **First Name:**_____

Phone: _____ **Relationship:**_____

Insurance Information

Please give your insurance card(s) to the receptionist

Primary Insurance: _____**Secondary Insurance:**_____

Insurance Holder:_____ **Insurance Holder:** _____

Member ID: _____ **Member ID:** _____

Group Number:_____**Group Number:**_____

Please fill out if patient is 18 or younger

Are vaccination records available: ***Y/N***

Mother's Information:

Last _____ **First:**_____

Address:

_____

City:_____ **State:**_____ **Zip:**_____

Phone Numbers:

Home _____ **Cell** _____

Date Of Birth _____

Father's Information:

Last _____ **First:**_____

Address:

_____

City:_____ **State:**_____ **Zip:**_____

Phone Numbers:

Home _____ **Cell** _____

Date of Birth _____

Employer Info:

Employer:_____

Address: _____

City:_____ **State:** _____ **Zip:** _____ **Phone:**_____

Patient Intake Health History

Previous Provider Name: _____

Last Visit: _____

Provider you would like to establish with at Midwest Health Clinic:

_____

How soon do you need to be seen: _____

Do you have any specific concerns to be addressed:

_____

_____

List any current medical problems or conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

☐high blood pressure ☐high cholesterol ☐anemia
☐ heart disease / murmur / angina ☐ heartburn (reflux)
☐ asthma or shortness of breath ☐ seizures ☐ diabetes
☐ headaches / migraines ☐ depression / anxiety
☐ arthritis ☐cancer ☐ thyroid problems ☐ulcers
☐ stroke ☐ seasonal allergies ☐ kidney problems

List any past surgeries or procedures:

1. _____
2. _____
3. _____

☐ Appendectomy ☐Hysterectomy ☐ Cataracts
☐ Gallbladder ☐ Hernia ☐ Tonsillectomy ☐Spine
☐ Heart vessel bypass ☐ Joint Replacement

List allergies and reaction

1._____ 3._____

2._____ 4. _____

List medications, dosage and how often taken:

1._____ 7._____

2._____ 8. _____

3._____ 9. _____

4._____ 10._____

5._____ 11. _____

6._____ 12. _____

Preferred Pharmacy

Name: _____

Location: _____

Midwest Medical Center and Midwest Health Clinic

Authorization to Release Information

Patient Name (Printed_____ Date of Birth:_____

I authorize:_____ _____

Previous Facility/Physician Street Address

_____ _____ _____

City State Zip Code Phone FAX #

To disclose the information described below to: MIDWEST MEDICAL CENTER / MIDWEST HEALTH CLINIC, One Medical Center Drive, Galena, IL 61036
HOSPTIAL PHONE: 815-777-1340 FAX: 815-776-7271 CLINIC PHONE: 815-776-7381 FAX: 815-776-7385

Please specify the information to be released:
☐ All medical records, including lab, x-ray, immunizations, and records and correspondence obtained from other healthcare providers.
The following categories are ***EXCLUDED*** from disclosure, unless specifically checked: ☐Mental health information (including ADHD); ☐ AIDS/HIV-related information, diagnosis, test results; ☐ Substance abuse (drug or alcohol). **OTHER**:_____

The requested disclosure of information is for the following purpose: _____

This authorization expires on ____/____/____, or if not specified, one year from the date signed. I understand that I may revoke this authorization at any time by a written request to do so. Midwest Medical Center/Midwest Health Clinic does not require completion of this form as a condition of evaluation or treatment.

The undersigned patient (guardian or legal representative, if applicable) hereby recognizes that the medical information and medical records sought to be disclosed are privileged and confidential, and subject to disclosure upon the authorization of the undersigned only, except where provided by law. The undersigned patient may review the disclosed information by contacting the Midwest Medical Center/Midwest Health Clinic, One Medical Center Drive, Galena, IL 61036; Telephone (815)777-1340 (hospital) or (815)776-7381(clinic). I further understand that recipients of this information may possibly re-release the information without proper authorization, and that once information is disclosed, it may no longer be protected by federal privacy regulations. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

X_____ _____
Signature of patient (or patient's legal representative) Date

Printed name of patient's legal representative:_____ _____
(Parent, Guardian, Healthcare POA, etc.) Relationship (if not the Patient)

The following must also be completed if the information to be disclosed is protected by the Illinois Mental Health and Developmental Disabilities Confidentiality Act, or the Federal Confidentiality of Alcohol and Drug Abuse Patient Records Act.

The specific nature of the information to be disclosed is:_____

The purpose of the disclosure is:_____

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any):
_____

I understand that the person or entity receiving this information has the right to inspect and copy the information to be disclosed:

Signed X_____ Date:_____

Witness:_____ _____ Date:_____
Signature Printed Name

NOTICE TO RECEIVING AGENCY/PERSON: *Release of Mental Health Information* (including ADHD): Under provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. *Release of Substance Abuse Information*: Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no information from such records herein authorized for release may be further disclosed without specific consent to such re-disclosure. *Release of AIDS/HIV Related Information*: Under Federal Privacy rules, AIDS/HIV related information may not be re-disclosed unless the person who consented to this disclosure specifically authorizes such re-disclosure.