HEALTHY WINGS FAMILY & PSYCHIATRIC HEALTHCARE

ADDITIONAL REGISTRATION INFORMATION – PLEASE PRINT LEGIBLY

Last Name: _____ First Name: _____ Date of Birth: _____

Religious Affiliation(s): _____ Today's Date: _____

Additional Past Medical History **Do you have an Advance Directive or Living Will? Y N**

	YES	NO		YES	NO	OTHER SURGERIES	DATE
Chicken Pox/Shingles			Mental Health Issues			Appendectomy	
Female Disorder(S)			Type?			Gallbladder Out	
Hay Fever/Allergies			Nervous Breakdown			Hernia Repair	
Headaches/Migraines			Prostate Trouble			Hysterectomy	
Hemorrhoids			Varicose Veins			Tonsillectomy	
Hernia			Sexually Transmitted Disease			Other	
TB/Tuberculous			Type?				

How often do you visit a healthcare provider? (Circle One): Monthly Every 3 Months Yearly Hate Docs-Only When Needed :))

Date of Last Vaccine:

Tetanus Shot: _____ Pneumonia Shot: _____ Flu Shot: _____

Date of Last Screenings/Exams:

Last Physical Exam: _____ Last Blood Work/LABs: _____

Last Eye Exam: _____ Dental Exam: _____ Last EKG: _____

Last TB Skin Test: _____ Last Colonoscopy: _____ **MEN ONLY** Last PSA: _____

WOMEN ONLY:

Last Bone Density Test: _____ Age Started Menstrual Cycle: _____ Last Menstrual Period: _____

Additional Lifestyle Factors – Daily Habits:

Water: #Cups/Day _____ Vegetable(s): #Servings/Day _____ Fruit(s): #Servings/Day _____

Pasta/Rice: #Servings/Week _____ Meat(s): #Servings/Week _____ Poultry: #Servings/Week _____

Seafood/Fish: #Servings/Week _____ Bread(s): #Servings/Day _____ Other Snack(s): #Servings/Day _____

IN THE PAST 2 WEEKS HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (Circle the Symptoms you have had):

General	Fever; chills; night sweats; weakness; **Travel outside the U.S. w/in the past 30 days?** Y N Where?
Neuro	Head injury; headaches, dizziness; light headedness; fainting; seizure; numbness or tingling in hands or feet; decreased sensations; tremors, twitching, or balance problems.
Eyes	Pain; redness; excessive tearing; irritation; Cataracts; **Do you wear glasses or contacts?** Y N
Ears, Nose, Mouth, Throat	**Hearing** - ringing; spinning sensation; earaches; **Do you wear hearing aids?** L R BOTH; **Sinus/Nose** – nosebleeds; runny nose; nasal congestion; itchy nose; sores in or around nose; **Throat** – swallowing difficulties; sore throat; or hoarseness; **Teeth or Mouth** – sores in or around mouth; toothache; bleeding gums; **Do you wear dentures?** TOP BTM BOTH; **Fit?** Y N
Neck	Neck stiffness; pain; swollen glands; lumps.
Breasts	Lumps; pain; discomfort; nipple discharge; **Do you practice self-breast-exams monthly?** Y N
Cardio	History of high blood pressure or blood clots in legs; chest pain; palpitations/racing heart; leg swelling; swollen veins; Do you have difficulty breathing especially night? Y N
Respiratory	Any changes or difficulty breathing with exercise or when resting? Y N ; Do you have a history of asthma, bronchitis, emphysema, or pneumonia; wheezing, coughing a lot, pain with cough, cough with mucous or blood.
Stomach	History of jaundice, liver, or gallbladder problems; stomach pain; heartburn, lots of belching or gas; appetite changes; vomiting food or blood; nausea; diarrhea; constipation; pain with bowel movements; black or bloody stool; **Last BM: #/day?**
Urinary	**Pain with urination?** Y N ; Any pain in the back, side, or pelvic areas? Y N ; blood in the urine; strong odor; discharge; increase in urgency, frequency, or nighttime urination; dripping; hesitancy; decreased urine stream force. History of kidney stones or Urinary Tract Infection in the last month? – Y N
Musculoskeletal	Any joint stiffness, pain, or swelling, back or shoulder pain; muscle weakness; leg cramps; localized pain; History of gout; **Do you use a Cane, Walker, Wheelchair?** Y N ; **Date of MVA or Serious fall?**
Skin, Nail or Hair	Changes in size/color of moles; abnormal masses or sores; rashes/irritation or itching. Dry or coarse skin; brittle hair; loss of hair.
Endocrine	Excessive sweating; blurry vision; seeing double; dry mouth or very thirsty; very hungry; urinating more than before. **History of Thyroid disease? Y N ; Menopause Symptoms? Y N**
Hematologic	Easily bleed or bruise, Overly fatigued; **History of blood transfusion? Y N ; Any Reaction?**

DO YOU DESIRE AN EMAILED COPY OF HEALTHY WINGS, LLC's Notice of Privacy Practices & Patient-Provider Policies? Y / N
Do You Want Access to Your Health-Related Information Online Through Our Patient Fusion App? Y / N

Please provide us with your email address: _____

The following person has permission for disclosure & pick up of my medical records in my absence.
MUST HAVE PROPER ID.

Other Adult & Relationship: _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Notice of Privacy Practices & Patient-Provider Policies

I have read and agree to abide by Healthy Wings LLC's Patient-Provider Policies. If my healthcare account is sent to an attorney for collection, I agree to pay attorney's fees and collection expenses. The amount of the attorney's fees shall be established by the court and not by a jury in any court action.

Payment in full is expected at the time of service which may include your co-payment and/or your portion of your unmet yearly deductible or co-insurance amounts as well as any service fees that may not be covered by your insurance provider. If allowed, a delinquent account may be charged interest at 10% if not paid within ten (10) days of the initial invoice date; an additional late fee at 10% will be assessed on any remaining balance every 30 days thereafter for invoices that remains unpaid.

If any signer is entitled to medical benefits under any policy insuring the patient or any other party liable to the patient, the benefits are hereby assigned to Healthy Wings, LLC. for application towards the patient's account. However, it is understood that **THE PATIENT AND/OR THE UNDERSIGNED ARE RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS ACCOUNT; especially, if any policy that insures the patient fails to make payment or timely payment (within 45 days of bill submission) to Healthy Wings Family & Psychiatric Healthcare and/or the Healthcare Provider. In addition, instead of sending you a bill, you hereby authorize HWLLC to automatically charge your balance to the credit card provided at the time of service.**

Patient's Last Name: _____ First Name: _____ Date of Birth: _____

Signature of Patient/Parent or Guardian: _____ Date: _____

Witness: _____ Date: _____

COMPLETE THIS SECTION FOR PEDIATRIC PATIENT'S AGE 0 TO 10 YEARS OLD ONLY:

During Pregnancy Did the Birth Mother:	Yes	No
Have Medical Problems? Diabetes? Thyroid Disease? High Blood Pressure? If so, please explain:		
Use Any Medications? If so, please list:		
Use Alcohol/Other Drugs? If so, please list:		
Have Problems with Labor/Delivery?		
Child's Immunizations Up-to-Date? If no, list missing shots:		

Birth weight: _____ Length: _____ Head Circumference: _____ Place of Birth: _____
C-Section or Vaginal Birth? (Please circle one) Gestational age at birth (how close to due date was child) _____
No. of previous pregnancies for mother: _____ Breast or Bottle Fed? (Please circle one) #Days baby stayed in the hospital after birth? _____

Names & Ages of other children @ home:
What kind of Pets, if any, are in the home?

The following person(s) has permission to authorize medical care FOR MY CHILD IN MY ABSENCE. MUST HAVE PROPER ID.

Other Adult & Relationship: _____ Date of Birth: _____

Other Adult & Relationship: _____ Date of Birth: _____

Parent's/Guardian's Signature: _____ Date: _____