Date: ___/___/___

Registration Form

Wellness
BY DR. NATALIA LURAGUIZ M.D.

Patient Information

Last Name: _____ First: _____ Middle: _____ Marital Status (Circle One): Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If no, what is your legal Name? _____ Birth date: ___/___/___ Age: _____ Sex: ☐ M ☐ F

Preferred nickname? _____ Social Security no.: _____ Pharmacy: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____ Work Phone no.: (___) _____

Contact Information

Home Phone no.: (___) _____ Cell Phone no.: (___) _____ Email: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Insurance Information

Person responsible for bill: _____ Birth date: _____ Address (if different): _____ Phone Number: (___) _____

Is this person a patient here? ☐ Yes ☐ No

Occupation: _____ Employer: _____ Work Phone no.: _____

Primary Insurance

Subscriber's name: _____ Subscriber's S.S. #: _____ Birth Date: ___/___/___ Group #: _____ Policy #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (if applicable)

Subscriber's name: _____ Group #: _____ Policy #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact

Name: _____ Relationship: _____ Phone no.: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wellness by Dr. Natalia Luraguiz M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: ___/___/___

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Authorization to Release Healthcare Information

Patient Name: _____ Birth date: / /

Previous Name: _____ Social Security no.: _____

I request & authorize _____ to release healthcare information of the patient named above to:

☐ **Wellness By Dr. Natalia Luraguiz M.D.**
1534 Elizabeth Ave. Suite 401
Shreveport, LA 71101

☐ **Other** _____

The purpose of this authorization: ☐ Further Medical Care ☐ Personal ☐ Research Related Treatment

☐ Changing Physicians ☐ Legal Investigation or action ☐ Creating Health Information for Disclosure to a Third Party

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates: _____

☐ All healthcare information ☐ Other

Definition
Sexually Transmitted Disease (STD), as defined by law (RCW 70.24 et. Seq.), includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/ AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the Patient. This form must be dated within 1 year of receipt, and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Policy for instructions on how to revoke this authorization. We will not condition treatment on the completion of the authorizatio11 Also, please be aware that once information is disclosed per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Patient signature: _____ Date: / /

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

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Patient Intake Questionnaire

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Name: _____ Date of Birth: ___/___/___ Date: ___/___/___

Primary Care Physician: _____

Other Physicians you are currently seeing: _____

Active Medical Problems

Primary reason for visit, then list all current medical problems

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

Other past medical history: _____

Current Prescription Medicines (dosage of medicine and frequency):

Example: Lisinopril 20mg once a day for blood pressure

Over-The-Counter Medicines, Vitamins, Supplements:

Allergies (medication and resulting allergy):

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Surgeries (include year, surgeon, hospital):

Other Hospitalizations/Illnesses (include year, hospital):

Women

Date of onset of last period: ___/___/___

No. of Pregnancies: _____

No. of live births: _____

Birth control method: _____

Any history of hormone replacement? _____

Date of last pap: ___/___/___

Any abnormal paps?: _____

When: ___/___/___

Date of last Mammogram: ___/___/___

Have you ever had an abnormal Mammogram or biopsy? _____

Date of last Bone Density (DEXA) & result? _____

Is there any possibilty you could be pregnant? _____

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Vaccination History

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Date of last Tetanus/Diptheria/Pertussis (TDaP) vaccine:
____/____/_____

Date of last Influenza vaccine:
____/____/_____

Date of last Pneumovax or Prevnar vaccine:
____/____/_____

Date of last Shingles (Zostavax) vaccine:
____/____/_____

Have you received any other vaccines (Hep B, Hep A, MMR in adulthood, Menactra, vaccines for travel)? ☐ Yes ☐ No

Habits (Please check all that apply)

☐ Tobacco? How long have (or did) you use it? _____ How many per day? _____
Quit? ☐ Yes ☐ No When? ____/____/____

☐ Alcohol? ☐ monthly or less ☐ weekly ☐ several days per week

☐ Other drugs? What? _____

Social History

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ domestic partner

Are you sexually active? ☐ with spouse ☐ never ☐ with males ☐ with females ☐ both

Whom do you live with? _____

Do you have children? ☐ Yes ☐ No Occupation: _____

Family History (list any known health issues)

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Other: _____

☐ Alcohol or Drug Addiction in family? (list family member and addiction)

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Health Maintenance Exams Not Otherwise Covered

Date of last colonoscopy and result:

Date of last stress test and result:

Date and findings of last Ophthalmologic/Optometric/Eye exam and by whom:

Date of last PSA, results, and by whom:

Any other significant test results:

Review of Systems (mark any of the problems you are experiencing)

General: Chills Sweats Fatigue/Weakness Weight loss Weight gain

Sleep Hygiene: Change in sleep habits Loud snoring Waking self with snoring Insomnia

Head & Eyes: Head injury Headaches Visual loss/Blurriness Double vision Light Sensitivity Eye redness/discharge

Ears, Nose & Throat: Hearing loss Ears ringing Ear pain Nasal drainage Nose bleeds Sore throat Lip ulcers

Neck: Pain Stiffnesss Lumps or masses

Respiratory: Cough Sputum production Coughing up blood Shortness of breath @rest Wheezing Shortness of breath with exertion (more than anticipated) Chest pain with inspiration

Cardiovascular: Chest pain/Pressure Palpitations (heart racing) Awakening short of breath at night Shortness of breath when lying flat (need to prop head on pillows) Lower extremity edema Syncope (passing out) Pain in legs with walking that is relieved by rest (Claudication)

Breast: Lumps/Masses Pain Swelling Nipple crusting/discharge

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Gastrointestinal: ☐ Appetite Change ☐ Craving unusual foods ☐ Difficulty swallowing ☐ Pain swallowing ☐ Nausea ☐ Vomiting ☐ Vomiting blood ☐ Yellowing of skin/eyes ☐ Excessive belching ☐ Abdominal swelling/bloating ☐ Change in stool ☐ Dark/tarry stools or bright red blood in stool

General Genitourinary: ☐ Burning with urination ☐ Frequent daytime urination ☐ Frequent nighttime urination ☐ Blood in urine ☐ Urine incontinence

Male Genitourinary: ☐ Penile discharge/lesions ☐ ED ☐ Loss of libido ☐ Testicular pain ☐ Blood in urine ☐ Urine incontinence

Female Genitourinary: ☐ Vaginal discharge/bleeding ☐ Pain with menstrual flow/menses ☐ Loss of libido

Endocrine: ☐ Excessive appetite ☐ Excessive thirst ☐ Frequent urination ☐ Heat intolerance ☐ Cold intolerance ☐ Unusual hair loss on scalp ☐ Unusual hair growth on face/arms/torso/genitalia

Hematologic/Lymphatic: ☐ Easy bruising ☐ Excessive bleeding (especially after surgery or childbirth) ☐ Gum bleeding ☐ Lymph node or glands swelling

Musculoskeletal: ☐ Bone/joint pain ☐ Joint stiffness/swelling ☐ Muscular tenderness/atrophy ☐ Muscular weakness ☐ Back pain

Neurologic: ☐ Dizziness ☐ Tremor ☐ Poor balance ☐ Tingling/numbness in limbs ☐ Seizures ☐ Memory loss

Psychiatric: ☐ Depression ☐ Anxiety ☐ Any desire to hurt yourself or others ☐ Obsessions ☐ Emotional liability ☐ Hallucinations ☐ Delusions (false beliefs)

Skin/Integument: ☐ Rashes ☐ Skin pigmentation changes ☐ Worrisome moles/skin lesions ☐ Itching ☐ Hair loss ☐ Nail changes

Allergy/Immunology: ☐ Sinus pain ☐ Sinus congestion ☐ Watery/itchy eyes/nose ☐ Hives ☐ Swelling of lip/tongue

Please sign: _____ Date: ___/___/___

FOR MD USE ONLY

Cardiac Risk Factors: Age____ HTN____ Increased Chol____ Tobacco Use____ FH____ Prev. CAD____ Obesity____

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Patient Contact Policy

In caring for you, our patients, it will become necessary or desirable to contact you at some time. When you are not available to speak with us directly, we would like to leave you a message, send an email, or send a fax to a personal fax machine.

In order to protect your privacy, we have developed a policy for contacting you:

1. We will not leave messages (other than we tried to contact you) with anyone except you, the patient.
2. We will not leave information (other than we tried to contact you) on an answering machine.
3. We will not leave messages on a voice mail system.

Unless we have your written permission to leave messages for you or to contact you by phone, email, or fax. Please read the information below and indicate by what method(s) you would like us to contact you.

I, _____ give Wellness by Dr. Natalia Luraguiz M.D. my permission to contact me regarding my medical care in the following ways as of ___/___/___

Email Address: _____ Initials: _____

(Please realize that email is NOT secure - others may have access to your information once it leaves our office on the internet)

Home Phone Number: _____ Initials: _____

Office Phone Number: _____ Initials: _____

Cell Phone Number: _____ Initials: _____

Thank you!

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Medical Information Release Form

Name: _____ Date of Birth: ___/___/___

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ Information is not released to anyone _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number: _____

If unable to reach me: ☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

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Effective Date: ___/___/___ Membership Rate: _____

Payment Method | Credit Card

Name on Credit Card: _____

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____

Expiration Date: _____ Credit Card Security #: _____

Patient Name: _____ Zip Code: _____

Authorized Signature for Credit Card: _____ Date: ___/___/___

Authorization to Charge Credit Card for Deductibles/Co-Pays/Co-Insurance
(Receipt will be Mailed)

☐ Yes ☐ No Authorized Signature: _____

Payment Method | Automated Bank Draft

Name on Bank Account: _____

Bank Routing Number (lower left hand corner of check): _____

Bank Account Number: _____

Patient Name: _____

Authorized Signature for Bank Account: _____ Date: ___/___/___

Authorization to Process Bank Draft for Deductibles/Co-Pays/Co-Insurance
(Receipt will be Mailed)

☐ Yes ☐ No Authorized Signature: _____

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