Noble Parkway
Medical Clinic.

Address: 4808 85th Avenue North, Brooklyn Park, MN 55443
Suite # 300
Email: inquiries@nobleparkwaymc.com
Office: (763) 496-1562 | (763) 400-7908
Fax: (763) 657-0581

"We put the care in caring"

4808 85th Avenue North, Suite 300 Brooklyn Park, MN 55443

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home/ Cell Phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Can we leave a message on the number you have provided? ❑ Yes ❑ No			
What type of message can we leave you?	❑ Brief message	❑ Extended Message	

Race: ❑ American Indian ❑ Asian ❑ Native Hawaiian ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race ❑ Other Pacific Islander

Ethnicity: ❑ Hispanic ❑ Not Hispanic

Language: ❑ English ❑ Indian ❑ Spanish ❑ Russian ❑ Tagalog ❑ Thai ❑ Other_____

Primary Care Physician:	Phone No.:
Referring Physician:	Phone No.:
Pharmacy:	Phone No.:
Mail Order:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No					
Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]
❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ Welfare *(Please provide coupon)*	❑ Other	

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No					

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

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Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

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EMAIL AUTHORIZATION AGREEMENT

Privacy and security or e-mail

Do not use e-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use e-mail provided by your employer, any e-mail sent on your employer's system may be viewed by your employer.

Noble Parkway Medical Clinic cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that e-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through e-mail. This document along with Noble Parkway Medical Clinic's "Notice of Privacy Practices" constitutes a notice of privacy practices for e-mail use. Noble Parkway Medical Clinic may choose to discontinue email communication at any time.

Authorization to use e-mail

I have been informed of and understand the risks and procedures involved with using e-mail. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with my physician, and his/her associates, technicians and other healthcare providers.

You will be given a copy of this signed form to keep for your records.

Patient Signature:	Date:
Patient Representative (Relationship):	Date:
Patient e-mail address:	
Physician Signature:	Date:
Physician e-mail address:	Office Number:

Prescription History Consent

I give my consent to have Noble Parkway Medical Clinic to obtain my prescription history from external sources.

Patient or Authorized Person's Signature: _____
Date: _____

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AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS; THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR THE SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE. THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE NOBLE PARKWAY MEDICAL CLINIC TO FURNISH THE INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO NOBLE PARKWAY MEDICAL CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.
I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HER/HIS ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, E-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OF PART OF MY (PATIENT'S) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT:

I UNDERSTAND THAT NOBLE PARKWAY MEDICAL CLINIC MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES NOBLE PARKWAY MEDICAL CLINIC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW NOBLE PARKWAY MEDICAL CLINIC IS PRIVACY NOTICE TO REQUEST RESTRICTIONS IS PUT ON THE USE OF MY INFORMATION, AND REVOKE MY CONSENT later.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, OR OPERATIONS, NOBLE PARKWAY MEDICAL CLINIC MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES NAD SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTENT THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT NOBLE PARKWAY MEDICAL CLINIC MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO NOBLE PARKWAY MEDICAL CLINIC.

HIPPA ACKNOWLEDGEMENT: I HAVE RECEIVED AND READ NOBLE PARKWAY MEDICAL CLINIC 'S NOTICE OF PRIVACY PRACTICES.
IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN

AUTHORIZED REPRESNTATIVE(S)			
Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone #. ( )	Work Phone #. ( )
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 [Name of Practice] or insurance company to release any information required processing my claims.			
Patient/Guardian signature		*Date*	

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

Patient/Guardian signature Date

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PATIENT PRIVACY & AUTHORIZATION AND FINIANCIAL DISCLOSURE FORM

Privacy & Authorization Policies

I hereby give my consent to the **Noble Parkway Medical Clinic** to use and disclose protected health information **(PHI)** about me to carry out treatment, payment and health care operations **(TPO)**. The Notice of Privacy Practices provided by the **Noble Parkway Medical Clinic** describe such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent form. The Noble Parkway Medical Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Noble Parkway Medical Clinic.

The Noble Parkway Medical Clinic may: call my home or alternative locations, leave a voice-mail message, or contact me in person in regards to any items that assist the practice with carrying out **TPO** (i.e. appointment reminders, insurance items and an calls pertaining to my clinic care, including laboratory test results).

By signing this form, I am consenting to allow the Noble Parkway Medical Clinic to use and disclose my **PHI** to carry out **TPO**.

Release of Information: I authorize the Noble Parkway Medical Clinic to release electronic and fax copies(i.e. diagnoses and records of treatment) concerning my medical records to insurance companies, referral physicans, hospitals, or dental offices for the purpose of continuing care and/or research purposes.

Finiancial & Privacy Policies

Payment Policy: You will receive a monthly statement and we ask that you pay your account in full each month. Please verify that the insurance information that you provided to clinic is true and accurate to the best of your knowledge and given to the clinic for the purpose of receicving medical care. As the responsible party of the account, by intialing, you understand and agree to pay for such treatment under the terms the clinic has outlined.

Assignment of Benefits: I hereby authorize and direct my insurance carries to issue payment to the Noble Parkway Medical Clinic directly for any services provided to me for which I am entitled to receive medical beneifts. I am fully aware that I am fully responsible for any costs that are not covered by my insurance company.

I understand that my signature below grants the Noble Parkway Medical Clinic the right to do all that I have read above, in accordance to their Notice of Privacy Pratices.

Signature of Patient or Legal Guardian **Date**

_____ _____

Print Patient's Name

_____

Patient Phone Number

_____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Reason for Today's Visit: _____

Current Medications (Prescription and over the counter)

Name	Strength/Dose	How Often Taken

Medical History

(List any chronic illnesses you have had. Please include dates.)

A. _____ G. _____
B. _____ H. _____
C. _____ I. _____
D. _____ J. _____
E. _____ K. _____
F. _____ L. _____

Allergies

Do you have any allergies? If so, please list them. If no, please mark N/A.

_____

_____

OB/ GYN HISTORY (women only)

1. How many pregnancies have you had? _____
2. How many living children do you have? _____
3. How many "C" sections have you had? _____
4. How many normal vaginal delivery births did you have? _____
5. Date of last period? _____
6. Date of last mammogram? _____
7. Date of your last bone density test? _____
8. Are you sexually active now? ..... No Yes
9. What was the date of your last Pap smear? _____
10. Have you reached menopause? ..... No Yes
    If yes, what was the age of attainment? _____

Surgical History

Have you had any surgeries? If yes, please list them with the year. If no, please mark N/A.

_____

Hospitalization

Have you visited the hospital recently? If yes, please list them. If no, please mark N/A.

_____

FAMILY HISTORY

Please indicate any medical condition in family members (e.g. diabetes, heart disease, high blood pressure, cancer (breast, colon, other), lung disease (emphysema, asthma), kidney disease, bleeding tendencies, anemia, arthritis, stroke, glaucoma, migraine headaches, mental illness, etc.)

			Age/Age at Death	Mental Illnesses/Causes of Death
Father	deceased	living	_____	_____
Mother	deceased	living	_____	_____
Brothers (How many? _____)	deceased	living	_____	_____
Sisters (How many? _____)	deceased	living	_____	_____

1. Does your family have any history of cancer? ..... No Yes
   If yes, who and what type of cancer? _____
2. Does your family have a history of osteoporosis or hip fracture? ..... No Yes
   If yes, who? _____
3. Does your family have a history of heart disease or heart attacks before age 60? ..... No Yes
   If yes, who and what age? _____
4. Any family history of diabetes? ..... No Yes
   If yes, who? _____

Any other history of family illness: _____

_____

SOCIAL HISTORY

1. Do you smoke? ..... No Yes
   If yes, how many packs a day? _____ How many years? _____
2. Do you drink alcohol? ..... No Yes
3. Do you use any other types of recreational drugs? ..... No Yes
   If yes, what? _____
4. How many caffeinated beverages do you consume a day? _____
5. Have you been abused verbally or physically in any way? ..... No Yes
   If yes, what type of abuse did you suffer? _____
6. Date of last tetanus booster? _____
7. Do you travel outside of the United States? _____
8. Where do you live? (circle) home nursing home assisted living
9. What is your natural support system? (circle) family friends government assistance
10. Do you exercise? ..... No Yes
    If yes, how many times per week? _____ Type of activity? _____

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General/Constitutional

- ☐ Recent weight change
- ☐ Change in appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats

Ophthalmology/HENT

- ☐ Blurred vision
- ☐ Double vision
- ☐ Abnormal eye discharge
- ☐ Facial pain
- ☐ Runny nose
- ☐ Hearing loss
- ☐ Disturbances of smell
- ☐ Ear pain
- ☐ Ringing in the ears
- ☐ Sore throat

Endocrine

- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Heat intolerance

Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular

- ☐ Chest pain
- ☐ Ankle/Leg Swelling
- ☐ Irregular heartbeat
- ☐ Orthopnea
- ☐ Palpitations

Gastrointestinal

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting blood
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

Hematology

- ☐ Groin mass
- ☐ Prolonged bleeding
- ☐ Recent transfusion
- ☐ Swollen glands

Genitourinary

- ☐ Pus or blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Itchy genitals
- ☐ Decreased sexual desire

Musculoskeletal

- ☐ Muscle cramps or pain
- ☐ Joint pain or stiffness
- ☐ Back pain or stiffness

Skin

- ☐ Hair loss
- ☐ Jaundice
- ☐ Dry skin
- ☐ Itching

Neurologic

- ☐ Slurred speech
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory loss
- ☐ Seizures
- ☐ Numbness

Psychiatric

- ☐ Anxiety
- ☐ Depressed mood

Females

- ☐ No menses
- ☐ Menstrual irregularity
- ☐ Painful or heavy periods
- ☐ Abnormal vaginal discharge

- ☐ Other _____

Males

- ☐ Impotence(weak male erection)
- ☐ Scrotal pain
- ☐ Abnormal penis discharge

Explanation

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

*__If you are not currently experiencing any of these problems, please indicate so on the line below.__

_____