Patient Registration Form

Patient Name: First | Middle | Last

Date of Birth: **Social Security #:** **Gender:** ☐ **Male** ☐ **Female**

Level of Care: ☐ **Independent Living** ☐ **Assisted Living** ☐ **Memory Care** ☐ **Skilled (TCU or SNF)**

Community Name: **Nursing Ph #:**

Address: Street | City | State | Zip

Healthcare Decision Maker / Medical POA

Name: First | Middle | Last

Relation to Patient: **E-Mail Address:**

Primary Phone #: **Secondary Phone #:**

Address: Street | City | State | Zip

Billing Contact

☐ **Check box, if same as Healthcare Decision Maker / Medical POA**

Name: First | Middle | Last

Relation to Patient: **E-Mail Address:**

Primary Phone #: **Secondary Phone #:**

Address: Street | City | State | Zip

Insurance Information

Medicare ID #:

Primary Plan Name:

Primary Policy ID #: **Primary Group #:**

Secondary Plan Name:

Secondary Policy ID #: **Secondary Group #:**

Patient Health History

Previous Primary Provider Name:		**Phone #:**	
Name of Pharmacy:		**Phone #:**	

List of Medications	**Dosage**	**Frequency of Medication** (taken how often)

Current Diagnosis & Past Medical Concerns:

Allergies:

Surgical History (last 5 years) or Recent Hospitalizations (including geri-psych):

Last Vision Exam: (dates)		**Tobacco User?** ☐ **Yes** ☐ **No**	**If yes, how often?**	
Last Dental Exam:		**Former Smoker?** ☐ **Yes** ☐ **No**	**If yes, quit date:**	
Last Flu Immunization:		**Drink Alcohol?** ☐ **Yes** ☐ **No**	**If yes, frequency?**	
Last Pneumonia Immunization:		**Former Drinker?** ☐ **Yes** ☐ **No**	**If yes, quit date:**	

Social History: (occupation, interests, what is most important to patient?)

Checklist of Registration Information

- ☐ ***Authorization to Release Protected Health Information Form***
- ☐ ***Patient Registration Form***
- ☐ ***Current History & Physical (H&P)*** **from healthcare provider**
- ☐ ***Current Medication List*** **from healthcare provider**
- ☐ ***Copies of ALL Insurance Cards***
- ☐ ***Consent for Services and Insurance – HIPAA Acknowledgement***
- ☐ ***Documentation for Medical Power of Attorney, Health Care Directive or Guardianship (if activated)***

Please send All Information to Hometown Physician Services:

Scan & Email: **enrollment@hometownphysicianservices.com**

Via FAX: **715-997-7044**

Via Mail: **Hometown Physician Services**
8687 Eagle Point Blvd
Lake Elmo, MN 55042

Questions? Please contact our *Enrollment Coordinator:*

enrollment@hometownphysicianservices.com
Main: 715-600-0549
Direct: 612-804-4443

Please visit **www.hometownphysicianservices.com** to learn more

Patient centered, on-site primary care, our clinic visits you!