SOUTHERN COOS HOSPITAL & HEALTH CENTER

Quality Healthcare With a Personal Touch

Patient Registration Form

Patient Demographic Information

Patient Name: (Last, First, M.I.)		Social Security Number: ___ - ___ - ____	Preferred Name:
Date of Birth: (M / D / YY)	Sex at Birth: ☐Male ☐Female	Mailing Address: City: State: Zip:	
Gender Identity:	Religion:	Home Address: City: State: Zip: ☐Same as above	
Ethnicity: ☐ Non-Hispanic/Latino/Latina ☐ Hispanic/Latino/Latina	Race: ☐White ☐Asian ☐Native American ☐Alaskan Native ☐African American ☐Native Hawaiian ☐Pacific Islander ☐More than one race ☐Other:		Patient Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Domestic partner
Employment Status: ☐Employed Full-time ☐Unemployed ☐Employed Part-time ☐Retired	Employer Name:	Do you have an Advance Directive, POLST, Living Will, or Power of Attorney? ☐No ☐Yes, type:	

Communication Preferences

Phone: ☐Home ☐Cell ( ) -	Email Address:	
Preferred Communication Method: ☐MyChart ☐Text Message ☐Phone Call ☐Email ☐Other:		
Preferred Emergency Contact Name:	Relationship to Patient:	Emergency Phone Number: ( ) -

Responsible Party Information

Relationship to Patient: ☐Self (skip ahead) ☐Other:	Responsible Party Name:	Resp. Party Social Security Number: ___ - ___ - ____
Resp. Party Phone Number: ( ) -	Mailing Address: City: State: Zip: ☐Same as above	
Are you self-pay / uninsured? ☐No ☐Yes (skip to next page)		
Primary Insurance Company:	Policy/Member ID Number:	Policy Group Number:
Policy Holder Name: ☐Same as above	Policy Holder DOB: ☐Same as above	Policy Holder Social Security Number: ☐Same as above
Secondary Insurance Company:	Policy/Member ID Number:	Policy Group Number:
Policy Holder Name: ☐Same as above	Policy Holder DOB: ☐Same as above	Policy Holder Social Security Number: ☐Same as above

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Health History – Adult

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Current Doctors / Providers / Specialists			
Are you transferring from out of state? ☐No ☐Yes, I am transferring from (city, state):			
Provider Type	Provider and Facility Name	Provider Type	Provider and Facility Name
Primary Doctor		Orthopedic Doctor (Bone/Muscle)	
Cardiologist (Heart)		Otolaryngologist (Ear/Nose/Throat)	
Dermatologist (Skin)		Pain Management	
Endocrinologist (Hormone)		Physical Therapy	
Gastroenterologist (Stomach)		Psychiatrist/Counselor	
Nephrologist (Kidney)		Pulmonologist (Lung)	
Neurologist (Nervous System)		Rheumatologist (Autoimmune)	
OB/GYN (Women's Health)		Social Worker/Case Worker	
Oncologist/Hematologist (Cancer)		Urologist (Kidney/Bladder)	

Current Medications:

List all prescriptions, over the counter, and any other medications that you currently take.
Please include any herbal or nutritional supplements, inhalers, eye drops, ointments, etc.

Preferred Pharmacy and Location:

Medication	Dose	Frequency
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:
		☐Daily ☐As Needed ☐Other:

Allergy Information

☐No Known Allergies ☐Medications ☐Tape/Adhesive (band-aids) ☐Latex ☐Food ingredient (gluten, lactose, etc.)

Allergen	Reaction	Allergen	Reaction

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Surgical History			
Operation/Procedure (bilateral, left, right, etc.)	Date	Reason	Hospital/Facility
(c-section, hysterectomy, tubal ligation, etc.)			

Current Medical Concerns (not past history): List your current complaints, conditions, and concerns	
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term
	☐Short-Term ☐Long-Term

Past Medical History (not current issues)			
☐ Abuse (child, adult)	☐ Blood Clots	☐ Gall Stones	☐ Liver Problems
☐ Abnormal Heart Rhythm	☐ Breast Lump	☐ GERD	☐ Lung Disease
☐ Abnormal Pap Smear	☐ Cancer (specify)	☐ Glaucoma	☐ Mental Illness
☐ HIV/AIDS	☐ Cataracts	☐ Headaches	☐ Multiple Sclerosis
☐ Alcoholism	☐ Chronic Bronchitis	☐ Heart Disease	☐ Pacemaker
☐ Anemia	☐ Crohn's Disease	☐ Hepatitis	☐ Pneumonia
☐ Anorexia/Bulimia	☐ Colon Polyp	☐ Hernia	☐ Sleep Apnea
☐ Asthma	☐ COPD/Emphysema	☐ Herpes	☐ STD/STI
☐ Atrial Fibrillation	☐ Coronary Artery	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Bladder Problems	☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Blood Transfusion	☐ Diabetes	☐ Irregular Periods	☐ Thyroid Problems
☐ Bleeding Disorder	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Tuberculosis

Preventive History					
Screening	Result	Date	Screening	Result	Date
Colonoscopy	☐Normal ☐Abnormal		Pap Smear	☐Normal ☐Abnormal	
Cologuard	☐Normal ☐Abnormal		Influenza Vaccine	☐ Decline Vaccine	
Fecal Occult Stool Test	☐Normal ☐Abnormal		COVID-19 Vaccine	☐ Decline Vaccine	
DEXA/Bone Density Scan	☐Normal ☐Abnormal		Pneumonia Vaccine	☐ Decline Vaccine	
Mammogram	☐Normal ☐Abnormal		Shingles Vaccine	☐ Decline Vaccine	

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Family Medical History:

Mark any family member who has experienced any of the following conditions

Condition	Mother	Father	Sister(s)	Brother(s)	Child(ren)	Grandmother	Grandfather
Arthritis	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Cancer (specify)	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Depression	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Diabetes	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Heart Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
High Blood Press.	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Kidney Disease	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Stroke/TIA	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Substance Abuse	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal
Other:	☐	☐	☐	☐	☐	☐Maternal ☐Paternal	☐Maternal ☐Paternal

Social History

Exercise Routine:	☐Yoga ☐Walking ☐Other:	Days per Week:	Minutes of Exercise:
Tobacco Use:	☐Cigarettes ☐Smokeless Tobacco (chew, pouch, etc.) ☐Other:		Packs per Day:
Frequency:	☐Never ☐Daily ☐Some Days ☐Quit	Usage Dates: From _____	to _____
Vape Use:	☐Nicotine ☐THC ☐CBD ☐Other:		Cartridges per Day:
Frequency:	☐Never ☐Daily ☐Some Days ☐Quit	Usage Dates: From _____	to _____
Substance Use:	☐Marijuana ☐Amphetamines ☐Narcotics ☐Heroin ☐Other:		
Frequency:	☐Never ☐Not Currently ☐Recovering Addict ☐ I Use # _____ Times per Week		
Alcohol Use:	☐Wine ☐Beer ☐Liquor ☐Other:	Num of Drinks per Sitting: ☐1-2 ☐3-4 ☐5-6 ☐6+	
Frequency:	☐Never ☐2-4 Times per Month ☐2-3 Times per Week ☐4+ Times per Week ☐Alcoholic		
Sexual Activity:	Are you sexually active? ☐Yes ☐No	Partner(s): ☐Male ☐Female ☐Other:	
Birth Control:	☐None ☐Condom ☐Pill ☐Patch ☐I.U.D. ☐Surgical ☐Injection ☐Other:		

Women's Health History

Number of Pregnancies:	Number of Live Births:	Number of Miscarriages/Abortions:
Have you had a Mammogram Within the last 10 Months? ☐Yes ☐No		Result of Mammogram: ☐Normal ☐Abnormal
Are your Periods Regular each month? ☐Yes ☐No	Do you have Abnormal Bleeding? ☐Yes ☐No	

Southern Coos Hospital & Health Center
900 11th Street, SE
Bandon, OR 97411

Phone: (541) 347-2426
Fax: (541) 347-7324
medicalrecords@southerncoos.org

Authorization for Use and Disclosure of Health Information

Where are the records being released from?

Facility Name:
Address:
City: State: Zip:
Phone: Fax:

Patient Information

Name: DOB:
Email:
Address: City: State: Zip:
Phone: Fax:

Records being released to:

Name: **Southern Coos Hospital & Health Center**
SECURE Email: **medicalrecords@southerncoos.org**
Address: **900 11th St SE** City: **Bandon** State: **Oregon** Zip: **97411**
Phone: **541-347-2426** Fax: **541-347-7324**

What would you like released? Check all that apply.

- ☐ Medical Records last 2 yrs (industry standard)
- ☐ Office/Clinic Notes
- ☐ Operative Reports
- ☐ ED / Inpatient Visit
- ☐ Lab/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ All Records
- ☐ Other: Dates: to

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- ☐ Drug/alcohol diagnosis, treatment, or referral Info
- ☐ Genetic Testing Information
- ☐ AIDS/HIV Information
- ☐ Mental Health Information

Purpose of Disclosure:

- ☐ Continuation of Care
- ☐ Transfer to New Physician

Patient's Signature

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time, by sending a written authorization to: Southern Coos Hospital & Health Center, c/o Medical Records, 900 11th Street, SE, Bandon, OR 97411. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. This authorization will expire in 6 months from the date sign.

Patient's Signature: Date:
Relationship to Patient: