

# FRONTIER HEALTH AND WELLNESS, LLC

## Patient Registration Form – Adult



Date				
Patient Full Legal Name (First, Middle Initial, Last)		Prefix	Suffix	Previous Name(s)/Alias:
Previous Name(s):		Date of Birth	Age	Sex
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Preferred Pronoun	Gender Identity	
Patient Preferred Phone Number Can we leave a Voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No		E-Mail		
Physical Address		City, State	Zip Code	
Mailing Address		City, State	Zip Code	
Occupation		Employer	Contact Number	

Reason for choosing Frontier Health and Wellness <input type="checkbox"/> Recommendation from Family/Friend <input type="checkbox"/> Location/Convenience <input type="checkbox"/> Referral from Another Provider <input type="checkbox"/> Search Engine <input type="checkbox"/> Insurance <input type="checkbox"/> Other		
If referred by hospital or clinician, please list who:		
Preferred Pharmacy	Address	Contact Number
Emergency Contact	Relationship	Contact Number

**Please Do Not Include Information on Denali KidCare, Medicaid, or Medicare - We Do Not Accept These Plans**

Financially Responsible Party (if other than patient)	Address	Contact Number
Primary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
	If same, please do not complete the next 2 rows	
Policy Number/Member ID <small>(Do Not Include Medicaid/DKC/Medicare)</small>	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4
Secondary Insurance Carrier (Do Not Include Medicaid/DKC/Medicare)	Subscribers Name	
	If same, please do not complete the next 2 rows	
Policy Number/Member ID <small>(Do Not Include Medicaid/DKC/Medicare)</small>	Group Number	
Patient's Relationship to Subscriber	Subscribers Date of Birth	Subscribers last 4

I certify that my answers are true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for any balance accrued. I also authorize Frontier Health and Wellness and/or its Contracted Providers to release any information required to process my claims.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Frontier Health and Wellness, LLC**  
**Late Cancellation/Missed Appointment Policy**

At Frontier Health and Wellness, LLC (FHW) we enforce a strict Late-Cancellation/Missed Appointment Policy

**Missed Appointment (MA):** Any appointment where the patient arrives 10+ minutes late to their scheduled appointment or misses their appointment without providing notification to FHW.

**Late Cancellation (LC):** The cancellation or rescheduling of a scheduled appointment less than 2 full Business Days prior to their scheduled appointment date and time.

**Examples**

**Scheduled Appointment:** 10:30am Monday

**Cancellation Window:** 10:30am the Thursday prior

**Scheduled Appointment:** 3:30pm Tuesday

**Cancellation Window:** 3:30pm the Friday prior

**Policy Guidelines**

**1<sup>st</sup> and 2<sup>nd</sup> Intake Appointments**

Prior to scheduling the first intake appointment each patient will be charged a \$100 deposit. This deposit will be used towards the patient's deductible, Co-Pay and Co-Insurance payments for the Intake Assessment and future follow-up appointments. If the patient has a LC/MA, to their 1<sup>st</sup> or 2<sup>nd</sup> Intake Appointment, the \$100 deposit will be used as a penalty fee.

Prior to rescheduling the LC/MA, the patient will be charged a deposit of \$200 dollars. This deposit goes towards the patient's deductible, Co-Pay and Co-Insurance payments for the Intake Assessment and future follow-up appointments. In the event of a second LC/MA the \$200 deposit will be used as a penalty fee, all appointments will be canceled, *and* the patient will no longer be eligible for services at FHW.

**Regularly Scheduled Appointments**

All Occurrences (LC/MA) are tracked and accrue throughout a rotating calendar year. Each Occurrence accrues a higher penalty which may lead to attendance probation and/or dismissal from FHW entirely.

- **1<sup>st</sup> Occurrence:** No Charge
  - We are aware that on rare occasions there are circumstances that are outside of everyone's control, which is why we allow for one occurrence free of charge.
- **2<sup>nd</sup> Occurrence:** Penalty - \$100 charge
- **3<sup>rd</sup> Occurrence:** Penalty - \$150 charge and attendance probation.
  - **Attendance Probation:** The patient is required to attend their next **4 scheduled appointments** without infraction, or they may face dismissal from the clinic.
- **4<sup>th</sup> Occurrence:** Penalty - \$200 Charge and dismissal from the FHW Clinic.

**Appointment Reminder Calls/Texts/Emails**

Confirmation/Reminder calls, emails and or text messages are a courtesy that FHW may provide on behalf of its Contracted Providers. The absence of a confirmation/reminder call, email and/or text does not invalidate the Late Cancellation/Missed Appointment Policy.

**Acknowledgment**

I have read the above Late Cancellation/Missed Appointment Policy from Frontier Health and Wellness on behalf of its Contracted Providers. I understand and accept all the terms set forth above. All my questions and concerns have been answered and addressed by FHW Staff or my Provider prior to signing and submitting this document.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Guardian Name (If applicable)

# Frontier Health and Wellness

## Patient History Questionnaire (Adult)

To better assist our providers, we are asking that you complete the following questionnaire prior to your initial appointment. If you need more space, please feel free to add pages as needed.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please provide a list of your previous (last 5 years) and current medical and mental health providers

Provider Type	Provider Name	Clinic/Hospital Name	Phone Number	Location (City/State)
Primary Care Provider <span style="float: right;">N/A <input type="checkbox"/></span>				
Previous Primary Care Provider (last 5 years) <span style="float: right;">N/A <input type="checkbox"/></span>				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) <span style="float: right;">N/A <input type="checkbox"/></span>				
Specialist(s) (Cardio, Neuro, Allergy, Pulmonology etc.) <span style="float: right;">N/A <input type="checkbox"/></span>				
Therapy <span style="float: right;">N/A <input type="checkbox"/></span>				
Psychiatry <span style="float: right;">N/A <input type="checkbox"/></span>				
Neuropsych Testing <span style="float: right;">N/A <input type="checkbox"/></span>				
Other: <span style="float: right;">N/A <input type="checkbox"/></span>				
Other: <span style="float: right;">N/A <input type="checkbox"/></span>				

Please list all the medications you are currently taking:  N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all of your previous psychiatric medication:  N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list all supplements/over the counter medications you are currently taking:  N/A

Medication Name	Dosage	Frequency	Taking for how long?	Side effects/concerns?

Please list any of your known allergies as well as the reaction that occurs:  No known allergies

Allergen	Severity of Reaction			Type of Reaction
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	

Current or previous substance use:  N/A

Substance	Frequency of Use						
Caffeine	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Tobacco/Vaping	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Alcohol	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Opioids/ Prescription Drugs	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Marijuana	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Hallucinogens	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Amphetamines	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	
Other:	<input type="checkbox"/> Daily	<input type="checkbox"/> Weekly	<input type="checkbox"/> 1-2x month	<input type="checkbox"/> Occasionally/Socially	<input type="checkbox"/> Tried it once or twice	<input type="checkbox"/> Never	

# Frontier Health and Wellness

## Patient History Questionnaire (Adult)

Family Medical History:  N/A

Medical Condition	Patient or Family History		Please list the Family Member(s) affected
Anemia	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Asthma/Respiratory Concerns	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Cancer	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Chronic Fatigue	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Concussion(s) or TBI	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Diabetes	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Epilepsy/Seizures	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Heart Disease/Condition	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
High Blood Pressure	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Insomnia	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Stomach/ GI Problems	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Stroke	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Substance Abuse	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Thyroid Disease	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	

Psychiatric history:  N/A

Psychiatric Condition	Patient or Family History		Please list the Family Member(s) affected
ADHD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Anger	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Anxiety	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Bi-Polar Disorder	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Depression	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Inpatient Psychiatric Care	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
OCD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
PTSD	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Schizophrenia	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	
Suicide	<input type="checkbox"/> Patient	<input type="checkbox"/> Family History	

Please list any of your surgical history or hospitalizations  N/A

Surgery/Reason for Hospitalization	Date(s)	Hospital	Doctor/Attending	Location (City, State)

Have you had any bloodwork completed within the last 6 months (if yes, who ordered the labs to be drawn):  Yes  No

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# Frontier Health and Wellness

## Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Sad most of the day				
Not interested in activities that used to be fun				
Cannot fall asleep most of the time				
Sleeping more than usual				
Loss of energy				
Do not spend as much time with friends as usual				
Do not bathe or clean self regularly				
Eating more than usual				
Blaming self				
Acting angry much of the time				
Acting unusually happy much of the time				
At times needing little or no sleep				
An Increase in Intrusive and Unwanted Sexual Behavior				
Talking so fast it is hard to understand				
Tense, nervous, worrying much of the time				
Panic Attacks: heart pounding, can't breathe, sweating				

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Date

# Frontier Health and Wellness

## Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Saw or had something bad or scary happen				
Often remembering something bad or scary happening				
Having bad dreams over and over				
Easily upset when reminded of something bad or scary				
Staying away from or will not talk about things that remind you of something bad or scary that happened				
Jumpy or scared easily				
Doing things over and over without a clear reason i.e. washing hands, touching things, checking locked doors				
Having problems paying attention				
Easily distracted				
Often forgetful				
Often fidgeting with hands or feet				
Lots of physical movement				
Talking a lot				
Problems at work				
Often acting without thinking				
Often loses temper				

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Date

# Frontier Health and Wellness

## Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Often found arguing				
Difficulties following rules or directions				
Bullying, threatening or intimidating others				
Starting physical fights				
Destroying property				
Stealing				
Lying				
Abandoning responsibilities				
Cruelty to others				
Fire setting				
Disciplinary actions at work				
Change in work performance				
Uncomfortable making eye contact with others				
Having problems communicating				
Repeating same movements over and over (i.e. wringing hands, rocking back and forth, snapping fingers)				
Difficulty noticing when others are trying to speak or interact with you				
No interest in making friends or interacting with others				

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Date

# Frontier Health and Wellness

## Presenting Problems and Symptoms Checklist - Adult

Recent = within the past 30 days In the past = greater than 30 days	None	Recently	In the Past	Supported By: Please provide further explanation
Unchangeable beliefs or ideas that others don't get/tolerate				
Difficulties following rules or directions				
Hearing voices when no one is there				
Seeing things when nothing is there				
Voices tell you to harm self				
Voices tell you to harm others				
Talking with words that do not make sense to others				
People say you show little emotion on your face				
Refusal to maintain adequate body weight within normal range				
Very scared of gaining weight				
Others tell me I'm skinny but I still feel fat				
At times I eat way too much food				
People tell me I exercise way too much				
I take laxatives to lose weight				
I force myself to vomit				

\_\_\_\_\_  
Client Name (Please Print)

\_\_\_\_\_  
Date