Affiliates of Family Medicine

REGISTRATION FORM

(Please Print)

Today's date:	Date first visit:

PATIENT INFORMATION

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

Social Security #:	Date of Birth: _______/____/_____

Preferred Language:	Race:	Ethnicity:

Street address:	Home phone: ( )	Cell phone : ( )

City:	State:	Zip Code:	Email Address:

Occupation:	Employer Name & Address:	Employer phone no.: ( )

How did you hear about us?:	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Other	Name of other family members seen here:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

You have the right, as a patient, to be informed about your condition(s) and the recommended medical treatment(s) to be used so that you may make the decision whether or not to undergo the treatment(s) or procedure(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment.

- I voluntarily request Dr. _________________ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to render primary healthcare services.
- I voluntarily consent to and authorize my healthcare services to be rendered by the above named healthcare providers.
- I understand my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants and other health care providers to perform such other treatment or procedures which are advisable in their professional judgment.
- I understand no warranty or guarantee has been made to me as to the results of my treatment or cure.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
- I have been given, or I will be given, an opportunity to ask questions about my condition(s), procedure(s) to be used, or treatment to be provided, and the risks and hazards involved. I believe I have sufficient information to give informed consent.

____

Patient/Guardian signature Date

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 Affiliates of Family Medicine to release any information required to process my claims.

____

Patient/Guardian signature Date

Affiliates of Family Medicine Health Assessment: Please fill out to the best of your ability.

Family History: Please indicate if your blood relatives have had any of the following:

Illness	Relation	Illness	Relation
AIDS or HIV		Glaucoma/Eye Disease	
Arthritis		Heart Disease	
Asthma		High Blood Pressure	
Bleeding Disorder		Kidney Disease	
Bowel Disease		Lung Disease	
Epilepsy/Convulsions		Psychiatric Care	
Chemical Dependency		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer type_____________		Other?___________ ___________________	

Social Habits: Have you used any of the following?

Substance	Check one	Amount per day?	For How Long?	When stopped?
Alcohol	Yes___ No___			
Tobacco products	Yes___ No___			
Caffeine	Yes___ No___			
Street Drugs Type__________	Yes___ No___			

- Are you sexually active? Yes___ No___ How many partners have you had in the last year?_______
- Do you exercise safe sex precautions? Yes___ No___ Would you like info on safe sex precautions? _____

Preventative: Please indicate the last time you had the following test/vaccine (MM/YY)- please note some are age dependent

Exam	Date	Result?	Vaccine	Date
Cholesterol Testing			Tetanus/Diptheria/Whooping Cough Booster	
Eye exam with dilation			Flu Vaccine	
Hearing Test			Hepatitis B Vaccine	
Colonoscopy/Sigmoidoscopy			Pneumonia Vaccine	
Tuberculosis Testing			Hepatitis A Vaccine	
Stool occult blood testing			Shingles Vaccine	
Males only: Prostate Exam and PSA level test			HPV vaccine	
Osteoporosis(DEXA) Scan				

Gynecological History: Please answer the below questions as they are applicable for you

Female Patients Only	Date	Results	Performed By?
Pap Smear			
Clinical Breast Exam			
Mammogram			
Osteoporosis DEXA Scan			
STD and HPV testing			

- Age of onset of menstrual cycles?______ Are they regular each month?______
- Age of menopause?_________ Hysterectomy?_______ Have you taken estrogen therapy? _________
- Preferred method of contraception?_______________ ____ Have you ever had an IUD? _______ Tubal ligation?________
- Number of pregnancies? ______ Number of live births?______ Have you had a C-section? _____
- Have you had any miscarriages or complications with pregnancies or deliveries? ________
  - If yes, please explain:____

Signature of Patient or Guardian____Date_________

Affiliates of Family Medicine Health Assessment: Please fill out to the best of your ability.

Are you allergic to any medications? Yes _____ No_____ If answer is yes, please describe below:

Medication Name	Describe the reaction (i.e. hives, rash)

Please list medications you are currently taking: (please include over-the-counter, supplements, and contraceptives)

Medication Name	Strength/Dosage	Frequency	Reason Why?

Past Medical History: Please indicate if you have been diagnosed with any illnesses below by checking the box. Please write the approximate date of diagnosis (Month/Year).

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
AIDS or HIV			Hepatitis (type______)		
Anemia			High Blood Pressure		
Alcoholism			High Cholesterol		
Allergies (not medication)			Hernia		
Anorexia/Bulimia			Kidney Disease/Failure		
Appendicitis			Liver Disease		
Arthritis			Lung Disease		
Asthma			Measles		
Cancer (type?_________________)			Migraines		
Chemical Dependency			Mononucleosis		
Chicken Pox			Mumps		
Cataract			Pneumonia		
Depression			Psychiatric Care		
Diabetes			Rheumatic Fever		
Esophageal Reflux			Ovarian Cysts		
Emphysema/COPD			Rubella		
Epilepsy/Convulsions			Stomach Ulcer		
Frequent Kidney or Bladder Infections			Sexually Transmitted Disease		
Frequent Lung Infection			Stroke/Ministroke		
Gallbladder Disease/Gallstones			Thyroid Problems (type______________)		
Gout			Tonsillitis		
Glaucoma/Eye Disease			Tuberculosis		
Heart Disease			Whooping Cough		

Surgical History: Please list any other operations, hospitalizations, or procedures you have had with date. (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian____Date_________

<u>Affiliates of Family Medicine</u>

Assignment of Benefits Form

<u>Financial Responsibility:</u>

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

<u>Assignment of Benefits:</u>

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment checks directly to **Affiliates of Family Medicine** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

<u>Authorization to Release Information:</u>

I hereby authorize **Affiliates of Family Medicine** to:

1. Release any information to necessary insurance carriers regarding my illness and treatments
2. Process insurance claims generated in the course of examination and treatment
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from **Affiliates of Family Medicine** on behalf of myself and/or my dependents, and understand, that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature___________________________________Date__________

Witness ____Date__________