Patient Registration Form

First Name: | Middle: | Last:

Patient's Preferred(Nick) Name :

Social Security Number: | Date of Birth:

Sex: Male ☐ Female ☐ | Status: Married ☐ Single ☐ Divorce ☐ Widow ☐ Widower ☐

Address:

City: | State: | Zip:

Home Phone: | Work Phone: | Cell:

E-mail Address:

Do you agree to appointment reminders, updates and health bulletins through email? Yes ☐ No ☐

Employer Name: | Employer Phone Number:

Employer Address:

City: | State: | Zip:

Name of Primary Care/Last Physician: | Co-pay Amount $

How did you hear about our Practice? Internet ☐ Newspaper ☐ TV Commercial ☐

Friend or Relative ☐ If other Sources, please state:

Person responsible for bill or parent (Complete only if different from patient)

Guarantors' Legal First Name: | Middle: | Last:

Social Security Number: | DOB

Relationship to Patient: Self ☐ Spouse ☐ ☐ Parent

Address:

City: | State: | Zip:

Home Phone: | Work Phone: | Cell:

E-mail Address:

Employer Name: | Employer Phone Number:

Employer Address:

City: | State: | Zip:

Who to call in an emergency?

First Name: | Middle: | Last:

Address:

City: | State: | Zip:

Home Phone: | Work Phone: | Cell:

Relationship to Patient: Spouse ☐ ☐ Parent Relative ☐

If other, please state:

Signature: ______________________________ | Date:

New Patient Health Survey

Today's date:

First Name: | Middle: | Last:

DOB: | Name of your regular physician: | Name of Clinic:

1A CHRONIC MEDICAL PROBLEMS (for example; high blood pressure, high cholesterol, diabetes, etc.) Please state:

1B. Reason for Today's Visit :

2. Prior Surgeries

Name of Surgery	Date of surgery
a. Name of Surgery:	Date of surgery:
b. Name of Surgery:	Date of surgery:
c. Name of Surgery:	Date of surgery:

3. BLOOD CONDITIONS

a. Have you had hepatitis? Yes ☐ No ☐ Date:

b. Have you been tested for HIV? Yes ☐ No ☐ Results (optional): Positive ☐ Negative ☐

c. Have you had a blood transfusion? Yes ☐ No ☐ Date:

d. Do you have blood clotting or bruising problems? Yes ☐ No ☐

4. MEDICATIONS

a. Are you currently taking any prescription medications? Please list below Yes ☐ No ☐

1:	3:
2:	4:

b. Are you currently taking any over-the-counter medications? ? Please list below Yes ☐ No ☐

1:	3:
2:	4:

5. ALLERGIES

a. Are you allergic to any medications? Please list allergies: Yes ☐ No ☐

1:	3:
2:	4:

b. Do you have environmental allergy/hay fever? Yes ☐ No ☐

c. Have you been tested for allergies? Yes ☐ No ☐

d. Do you have food sensitivities? Please list the foods below: Yes ☐ No ☐

Name of food:	Name of food:
Name of food:	Other allergies:

6. Do you smoke: Yes ☐ No ☐

How many packs per day? per day | How long? Years | If you quit, when? Date:

7. Do you drink alcoholic beverages? Yes ☐ No ☐ | How many drinks per week? /week Or month? /month

8. How often do you exercise? Sedentary ☐ Mild ☐ Frequently ☐ Daily ☐

9. FAMILY HISTORY

Mother living: Yes ☐ No ☐ | If No, Cause of Death:

Father living: Yes ☐ No ☐ | If No, Cause of Death:

Financial Policy

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please ask us if you have any questions.

INSURANCE

Due to all the various insurance plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our office does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contact information is located on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier.

Some insurance plans require an authorization for services in our office. It is your responsibility to acquire the appropriate paperwork. If the visit is not authorized, you will be responsible for the cost of services.

We will send your insurance carrier(s) a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

All co-pays are required to be paid at the time of your visit.

PAYMENT EXPECTATIONS

If you are not covered by insurance, you will be required to pay for your services on the date the service is received. All patients are required to pay co-payments prior to being seen. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty days of receipt of the statement. Our office accepts cash, checks and VISA/MasterCard. There will be a $25.00 charge for any returned check.

I have read and understand this policy.

Signature: **Date:**

Patient Name:

Patient consent for disclosure of information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In order to continue to provide you the quality of care you have become accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purpose of treatment, payment and operations (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights.

Accountability Act (HIPPA)

Specifically, we will need to disclose your private information under the following circumstances:

1. Sharing information for the purposes of treatment: We will share information with all members of your treatment team, both within this office and with and with other providers, (personal and institutional) in order to provide you quality care and the educational/wellness programs specified in your insurance plan.

2. Sharing your information for the purpose of payment: We will share all necessary information with your insurer(s), payer(s), government entities (such as Medicare, Medicaid, etc) and their representatives (including but not limited to) benefit determination and utilization reviews as well as representatives involved in the billing process (including but not limited to) claims representatives and billing companies.

3. Sharing information for purposes of operations: We will share information necessary for ongoing operations of this office, including credentialing processes, peer review, accreditation, and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the Privacy Officer if you ever decide to revoke your consent. Our Privacy Officer can be reached by dialing our main number.

Patient/Patient Guardian's signature:	Date:
Patient Name:	