ABC Family Medicine

PATIENT REGISTRATION FORM

WE DO NOT PARTICIPATE IN WORKMAN'S COMPENSATION OR NO FAULT

Date _____ **Chart # (office use):** _____ **Office Staff:** _____

PATIENT INFORMATION
(Please Print)

Patient's Name _____ _____ Male _____ Female

Address _____

City/Town _____ State _____ Zip Code _____

Date of Birth _____ Social Security Number _____

Home Phone _____ Cell Phone _____

Email _____ Marital Status _____

Employer's Name _____Employer's Phone _____

Employer's Address _____

Mother's Name/DOB (if patient is under age 21) _____

Father's Name/DOB (if patient is under age 21) _____

Name of Primary Insurance _____

Name of Secondary Insurance _____

Relationship to Insured: _____ Self _____ Spouse _____ Child _____ Other

Race: _____White _____Black/African American _____Native Hawaiian/Other Pacific Islander
_____American Indian/Alaska Native _____Asian _____Declined/Unknown __Other_____

Ethnicity: _____Hispanic/Latino _____Not Hispanic/Latino _____Decline/Unknown

Preferred Language _____

Preferred Pharmacy_____

Chart #: _____

GENERAL MEDICAL HISTORY

PATIENT'S NAME _____ DOB _____MALE _____ FEMALE _____

PRIMARY CARE DOCTOR _____ PHONE NUMBER_____

MEDICATIONS YOU ARE CURRENTLY TAKING:

_____ _____
_____ _____
_____ _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

Do you have a **LATEX ALLERGY**? YES_____ NO_____

Do you wear glasses ____YES ____NO Contacts ____YES ____NO

Please check if you have ever had the following:

___ AIDS
___ Asthma
___ Sinusitis
___ Crohn's Disease
___ Depression
___ Anemia
___ Hypertension
___ TIA/Mini Stroke
___ Emphysema
___ Colitis
___ Atrial Fibrillation
___ Congestive heart failure
___ CVA/Stroke
___ Glaucoma
___ Hypercholesterolemia
___ Seizure Disorder
___ Diverticulitis
___ Anxiety
___ Cancer – type: _____
___ Diabetes – type: _____
___ Coronary Artery Disease
___ Arthritis
___ Hernia – type: _____
___ Thyroid Disease
___ Mental Illness: _____

Please Identify Other Medical Issues: _____
_____

Please check off if you have ever had any of these surgeries:

___ Appendix ___ Angioplasty ___ PE / Ear tubes ___ Gallbladder ___ C-section ___Hernia
___ Tonsils ___ Splenectomy ___ Gastric Bypass ___ Mastectomy ___ Pacemaker
___ OTHER: _____ _____ _____

Have you had any recent hospitalizations? If so, please list with related dates: _____
_____

Please check off if you have a family history of the following: Please list relationship

___ Unknown _____ Adopted _____ Addiction _____ Cancer _____ Diabetes
_____ Heart Disease _____ Hypertension _____ Mental Illness _____ Stroke
___ Other – Please Identify _____

Smoke: ___ Never ___ Former ___ Less than 10 cigarettes a day ___ More than 10 cigarettes a day
Drink alcohol: ___ Denies ___ occasionally ___ Heavily
Drug Use: ____ Denies Drugs ___ Former Drug User ___ Current Drug User
If yes, please list: _____

When was your last : Colonoscopy__/___/____ Mammogram___/___/___

Bone density test___/___/___ Stress test___/___/___ Sleep study___/___/___

Patient HIPAA Awareness

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the U.S. Department of Health and Human Services Office for Civil Rights, we are not permitted to release patient information except stated in the Notice of Privacy Practice, or in accordance with your wishes as stated below.

This waiver authorizes ABC Family Medicine to send/give medical information as noted:

Patient Name (First)_____ (Last)_____ (Please Print)

Please answer the following. Circle Yes or No.

1. ***YES or NO*** Leave a voice mail recording including my Personal Health Information on my home/cell phone.

2. ***YES or NO*** Speak to an individual of my choosing (Personal Representative) regarding my Personal Health and Billing Information and permit him/her to receive prescriptions and/or test results on my behalf.

   Name of Personal Representative_____

   Relationship_____

   Phone Number _____

3. ***YES or NO*** Speak to an individual in the event of a medical emergency. _____ (Check if same as above)

   Name of Emergency Contact_____

   Relationship_____

   Phone Number_____

4. ***YES or NO*** Send an email notifying me to contact the office to discuss my lab/test results (we will ***not*** send Personal Health Information over the internet).

   Email address _____

On this date_____, I received/reviewed ABC Family Medicine's Notice of Privacy Practices, which describe how my medical information may be used and disclosed and explains how I can get access to this information.

The authorizations made above will remain in effect until I notify ABC Family Medicine in writing, by certified mail, of requested changes.

_____ _____

Signature of Patient or Legal Guardian Patient's Name

_____ _____

Print Name of Patient or Legal Guardian Today's Date

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

Your signature below forms a binding agreement between ABC Family Medicine (the provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills.

PLEASE INITIAL ALL

All charges for services rendered are due and payable at the time of service.

_____ I am responsible and expected to pay ABC Family Medicine for the following:

1. Any co-payment as set by my insurance carrier
2. Any unsatisfied deductible or termination of coverage
3. Any amount my insurance carrier deems my responsibility
4. Any amount considered non-covered by my insurance carrier

_____ **Co-Pays:** All co-pays are due at the time of service. If your insurance requires any additional co-pays you will be responsible for payment and will be billed for it.

_____ **Authorization to pay benefits to the physician:** Any and all insurance checks that may go directly to the patient MUST be signed over to ABC Family Medicine for payment for services rendered. Failure to do this, will result in the patient receiving a bill for services. I hereby authorize payment for medical services provided directly to an ABC Family Medicine physician. If I should receive any insurance payments, I am to sign the check over to ABC Family Medicine.

_____ **To obtain Payment for Treatment:** We may use and disclose your PHI (Protected Health Information) in order to bill and collect payment for the treatment and services provided to you. We reserve the right to disclose your information to our business associates such as billing companies, claim processing companies, collection agencies, and others that process our healthcare claims.

_____**Workman's Compensation/No Fault**: ABC Family Medicine is not a provider for No Fault or Workman's Compensation injuries. By initialing, you acknowledge your understanding that injuries of this class will not and cannot be submitted to your insurance company by you, or ABC Family Medicine for reimbursement.

_____ In the event the charges incurred are not paid in full when due, and collection activity is instituted, whether by a collection agency or an attorney (or both), **I agree to be responsible for, and pay**, in addition to the charges incurred, all costs associated with such collection activity including, but not limited to, reasonable collection fees, attorney fees, court costs, and contingent fees to collection agencies of not less than thirty percent (30%).

_____ ABC Family Medicine reserves the right to transfer unpaid balances to outside entities for collection, such as banks or other financial institutions who may report unpaid balances to credit bureaus.

_____The provider of service has the right to terminate services based on noncompliance of this agreement.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to ABC Family Medicine.

Patient Name: _____ Date: _____

Signature of Patient/Guardian: _____