Christian Family Medicine & Pediatrics

ADULT PATIENT REGISTRATION FORM

Please Print Clearly

Patient Information

Legal Name_____ Date of Birth_____

Social Security Number_____ Marital Status_____

(Circle One) Sex: M F *(Circle One)* Race: African American Asian Caucasian Other *(Circle One)* Ethnicity: Hispanic Not Hispanic

Mailing Address_____

City/ State/ Zip _____

Home Phone_____Cell Phone_____Work Phone_____

Email address:_____

Patient Employer_____Phone:_____ Student_____

Local Pharmacy of Choice_____ City_____ Phone:_____

Emergency Contact: _____Contact #_____Relationship:_____

Parent/ Guardian Information (Person who is legally responsible for above person)

Guardian Relationship: *(Circle One)* Self Spouse Mother Father Grandmother Grandfather Aunt Uncle Other

Guardian Name_____ Guardian Date of Birth_____ _____

Guardian S. S. # _____Marital Status_____ (Circle One) Sex: M F

Address_____

City/State/Zip_____ Guardian Contact # _____

Guardian Employer_____ Employer Phone Number_____

Insurance Information

Primary Insurance

Name of Ins. Co_____ Effective Date _____

Policy # _____ Group/ Plan # _____

Policy Holder's Name_____ Copay $_____

Policy Holder's S. S. # _____ Policy Holder's DOB_____

Policy Holder's Address_____

Policy Holder's Relationship to Patient _____Phone #: _____

Secondary Insurance

Name of Ins. Co_____ Effective Date _____

Policy # _____ Group/ Plan # _____

Policy Holder's Name_____ Copay $_____

Policy Holder's S. S. # _____ Policy Holder's DOB_____

Policy Holder's Address_____

Policy Holder's Relationship to Patient _____Phone #:_____

Patient Financial Responsibilities Notification

Insurance Claim Filing
We will submit all charges to all insurance (primary, secondary, etc.) as a courtesy to you. However, we do require payment at the time of service for all co-payments, deductibles, and co-insurance. We cannot bill your insurance unless you bring all current insurance information with you. It is your responsibility to provide us with complete and accurate information at EACH office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be "non-covered" under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. Copies of your information will be made for our files.

It is the patient's responsibility to inform us of any special requirements or specific facilities associated with your benefit plan. If we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out of network facility, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know what benefits are included under their insurance plan and ensure they are following all regulations/ rules defined in their plan.

Self Pay with No Insurance
A deposit will be required for all patients that do not have insurance coverage prior to seeing the provider. Payment in full is expected at the time of service unless billing arrangements have been made by our billing staff PRIOR to the visit.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

There is a $50.00 form fee for any forms presented to the office for completion not presented during a regular visit. Examples include: Disability, Adoption forms, Insurance claim forms, etc.

Payment in full or payment arrangements can be made on any outstanding balance. No payment activity within 120 days from the date of service will result in the account being turned over to an outside collection agency. The patient will be responsible for all collection fees, cost, interest, and/or attorney fees and will be applied to the outstanding balance.

Any account that has been turned over to a collection agency **MUST** be paid fully before any treatment is rendered. Failure to meet your financial responsibilities may result in discharge from the practice.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the primary care provider. I understand if there are any changes in my insurance coverage, I will notify my primary care provider immediately. I hereby give consent for treatment of myself to the primary care provider at Christian Family Medicine.

I request payment of authorized Insurance/Medicare benefits be paid to Christian Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness necessary to pay my medical claims and I hereby irrevocably assign payments to Christian Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. I also understand my medical records may not be released if I am not financially in good standing with Christian Family Medicine, Inc. A copy of this authorization shall be considered as valid as the original.

_____
Signature of Patient or Responsible Party (state relationship)

_____
Date

Christian Family Medicine & Pediatrics

NOTIFICATION OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Christian Family Medicine, Inc. has given me notification of their Privacy Practice for protected health information. I authorize Christian Family Medicine, Inc. to leave messages with the following person(s) regarding my visits, care, and/or account:

_____

Name *Relation*

_____

Name *Relation*

_____

Name *Relation*

In the above section please list ALL persons that you wish to have access to your personal health information. Under no circumstance will this information be released except by court order to anyone who is not listed above.

Please indicate your permission for our communication with you regarding your personal health information.
Check all that apply

- □ Telephone call to your home or cell
- □ Telephone call to your place of employment
- □ Leave a message at your home with someone
- □ Answering machine
- □ Fax

_____ _____

Signature of patient or guardian *Date*

Christian Family Medicine & Pediatrics

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM (Name of physician or facility releasing information)

I authorize release of my medical record from

Physician/ Facility			
Address	City	Zip	Phone

RELEASE TO (Name of physician or facility receiving information)

Please send my medical record to:

Physician/ Facility	Christian Family Medicine			
Address 79 Hwy 51 South	City Ripley	Zip 38063	Phone 731-635-8189	Fax 731-635-8126

RELEASE INFORMATION

Reason: ( ) Change of Insurance ( ) Transfer of Care ( ) Personal File ( ) ER Visit
( ) Moving out of area ( ) Specialist consultation ( ) Legal ( ) Other : _____

Please release the following (check all that apply)

RECENT H&P		LAST 3 OFFICE VISITS	
LAB REPORTS		RADIOLOGY REPORTS	
HOSPITAL REPORTS		OTHER:	

- Please allow 15 days for processing.
- Incomplete information will delay processing.
- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse. I authorize the release of HIV/HTLV/AIDS test results.

Signature of patient, parent, guardian, conservator, or patient representative. (Please circle)	Date
Witnessed by:	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.
This release is not valid retroactively.

Christian Family Medicine & Pediatrics

Comprehensive Adult New Patient Health History Questionnaire

Main reason for today's visit: _____

Other Concerns: _____

Please list healthcare providers and their specialty you see regularly: _____

_____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

_____

MEDICATIONS: Please list (or show us a printed record) of ALL prescriptions and non-prescription medications. This includes vitamins, supplements, and over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.

□ Check box if you brought a printed record of your medications (give it to the nurse and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How often?

ALLERGIES or intolerance to medications? □ None (If yes, to what & what reaction?) _____

_____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _____ w/ Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (Pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax _____ HPV _____

Health Maintenance Screening Tests:

Lipid (cholesterol) Date: _____ Result, if known _____

Sigmoidoscopy or Colonoscopy (circle one) Date (year): _____ Abnormal? □ No □ Yes Polyp? □ No □ Yes

Women Only:

Mammogram Most recent date/ where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/ where _____ Abnormal? □ No □ Yes

Bone Density Test Most recent date/ where _____ Abnormal? □ No □ Yes

Women's Health History:

Total number of pregnancies: _____ Number of live births: _____ Number of miscarriages: _____ Number of abortions: _____

Age at beginning of periods (menstruation): _____ Age at end of periods (menopause/ hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you would like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	Now	Past	Comments		Condition	Now	Past	Comments
Alchol/ Drug Abuse					Gout			
Allergy (Hay Fever)					Gynecological Conditions			
Anemia					Heart Attack			
Anxiety					Hepatitis			
Arthritis					High Blood Pressure			
Asthma					High Cholesterol			
Bladder/ Kidney Problems					Irritable Bowel Syndrome			
Blood Clot					Kidney Disease/ Failure			
Blood Transfusion					Kidney Stones			
Breast Lump					Liver Disease			
Cancer					Migraine Headaches			
Cataracts					Osteoporosis			
Colon Polyp					Pneumonia			
Coronary Artery Disease					Prostate Issues			
Depression					Seizure/ Epilepsy			
Diabetes					Skin Conditions			
Diverticulosis					Sleep Apnea			
Emphysema					Stomach Ulcer			
Fractures			Where?		Stroke			
Gallbladder Disease					Thyroid Issues			
GERD					Other:			
Glaucoma					Other:			

□ Check box if you have no history of significant medical illnesses.

SURGICAL & PROCEDURE HISTORY: Please check off any procedure or surgeries. List any abnormal finding, detail, or complication.

Surgical Procedure	Yes	Year	Details:		Surgical Procedure	Yes	Year	Details:
Abdominal Surgery					Hip Surgery			
Angiogram					Hysterectomy			
Appendectomy					Knee Surgery			
Back Surgery					LEEP (Cervix Surgery)			
Biopsy					Neck Surgery			
Breast Biopsy or Surgery					Ovary Removal			
Cataract Surgery					Pulmonary Function Test			
Colonoscopy					Sigmoidoscopy			
Coronary Bypass or Stent					Sinus Surgery			
C-Section					Stress Test or Echo			
Echocardiogram (Heart)					Tonsillectomy			
EGD (Stomach Endoscopy)					Tubal Ligation			
Gallbladder Removal					Vasectomy			
Heart Surgery (other than above)					Other:			

□ Check box if you have never had any medical procedures or surgeries.

FAMILY HISTORY: Please indicate which relative has had the following diseases. Write in the number of siblings in the appropriate boxes. If some siblings are alive and some are deceased use the space to the right to explain further.
Adopted? □ No □ Yes If adopted and you do NOT know your family history skip the Family History Section and continue to Health Issues.

	Mother	Father	* Sister(s)	*Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	List age(s) at diagnosis if known and mark if this disease/ condition was the cause of death.
Alive									
Deceased									
Age currently or at death									
Diseases & Conditions									
No significant history known									
Hypertension – high blood pressure									
Hyperlipidemia – high cholesterol									
Heart Attack, Angina									
Diabetes Type II (adult onset)									
Diabetes Type I (childhood onset)									
Cancer, (please specify type)									
Osteoporosis									
Depression									
Alcoholism/ Drug Abuse									
Alzheimer's									
Asthma									
Autoimmune disease									
Bleeding/ Clotting Disorder									
Colon Polyp									
Emphysema (COPD)									
Genetic Disorder (Please Explain)									
Glaucoma									
Heart Disease (CHF)									
Hepatitis									
Hip Fracture									
Hypothyroidism/ Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									
Other:									
Other:									

HEALTH ISSUES:

Tobacco Use: *(Circle all that apply)* Smoke or Smoked Cigarettes Pipe Cigars □ Never smoked

Current smoker: _____packs per day _____ # of years

Former Smoker: Quit date: _____

Approximately how many packs/ day did you smoke? _____

How many years did you smoke? _____

Exposure to second hand smoke? □ No □ Yes

Other tobacco? *(Circle all that apply)* Snuff Chew Currently Use: □ No □ Yes Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes, _____ drinks/week: □ Beer □ Wine □ Liquor

Drug Use:

Have you ever used recreational drugs? □ No □ Yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

Sexual Activity:

Are you sexually involved? □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/ may be in the future: □ Male □ Female □ Both

Birth control method or STD prevention *(Mark all that apply)*: □ None □ Condom □ Pill □ IUD □ Patch □ Ring □ Diaphragm □ Vasectomy □ Tubal Ligation □ Other Method: _____

Other (ADL):

Military Service? □ No □ Yes

Blood Transfusion? □ No □ Yes

Exposure to toxic chemicals at work? □ No □ Yes

Exposure to toxic chemicals doing hobbies? □ No □ Yes

Diet: Do you follow a special diet? □ No □ Yes, □ Vegetarian □ Vegan □ Gluten Free □ Other: _____

Exercise: Do you exercise regularly? □ No □ Yes, please specify kind: _____

How long (minutes)? _____ How often? _____

Do you use a helmet for recreational activities? □ Not applicable □ No □ Yes

Do you use seatbelts consistently? □ No □ Yes

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr., Mrs, Ms, etc): _____

Country of Birth: _____

Who lives at home with you? □ No one □ Spouse/ Partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, ext family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of the country in the past 6 months: _____

_____

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ Retired □ Unemployed □ On a Leave of Absence □ Disabled □ Homemaker □ Other: _____

Martital Status: □ Single □ Partner □ Married □ Divorced □ Widowed

Spouse/ Partner's Name: _____ # of Children: _____ Ages (if minors): _____

Education: □ High School Diploma/ GED □ Trade School □ College □ Graduate School □ Other: _____

MEDICAL FORMS:

Please check any of the following forms you have completed.

□ Advance Directive for Health Care (ADHC)
□ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will
□ POLST (Physician Orders for Life Sustaining Therapy
□ Know about these or have the forms but have not completed them
□ Don't know what these are

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Christian Family Medicine, Inc. of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____

Signature of patient/parent/guardian Date