New Patient Registration Information

Date: _____ / _____ / _____

Personal Information:

*** Name (Last, First, Middle Initial):_____**

*** DOB: _____/_____/_____ * Age: _____ * Sex: _____**

*** Social Security#: _____ * Marital Status: _____**

*** Address: _____ Apt#: _____**

*** City/ State/ Zip: _____**

*** Home Phone**: (____) _____ *** Cell:** (____) _____***Work:** (____) _____

*** Occupation: _____*OK to leave messages? _____**

*** Email Address: _____**

Insurance Information:

*** Primary Insurance Company: _____**

*** Policy ID#: _____**

*** Group#: _____**

*** Policy Holder's Name: _____**

*** DOB: _____ / _____/ _____**

*** Relationship:** ____Self ____Spouse ____Parent ____Other: _____

Pharmacy Information:

*** Pharmacy Name: _____**

*** Phone Number:** (_____) _____

*** Address: _____**

Emergency Contact Information:

*** Name: _____**

*** Phone#:** (____) _____ *** Relationship: _____**

Medical History:

*** Patient's Name**: _____ *** DOB:** _____/ _____/ _____

*** Allergies To Medicine:** ____NKDA

_____

_____

*** Current Medication / Dosage / Direction:**

_____

_____

_____

_____

*** All Surgeries, please include dates:**

_____

_____

_____

_____

Medical History:

*** Patient's Name:** _____ *** DOB:** ____/____/_____

Please circle appropriate diagnosis for Patient's Health History:

Stroke	Heart Trouble	High Blood Pressure	Arthritis
Diabetes	HIV/AIDS	Seizures	Mental Illness
Kidney Troubles	Cancer	Bleeding Disorders	Alchoholism
Serious Injuries	Lung Disease	Tuberculosis	Phlebitis
Anemia	Stomach Trouble	Liver Trouble	Thyroid Trouble
Asthma	Weight Gain	Weight Loss	Gout

Other Illness:_____

_____

_____

*** If you circled any of these please explain:**_____

_____

_____

_____

*** Last PCP Visit**: _____ *** Last Eye Exam:** _____

*** Last EKG: _____ * Last labs: _____**

*** Advance Directive: _____ * Do Not Resuscitate: _____**

*** Living Will: _____ * Health Care Surrogate: _____**

Family History:

**** Please Provide any Medical History for each Family Member, and/or Cause of Death:***

(Example: High Blood Pressure, Diabetes, Cancer, Thyroid Problems, Mental Disorders, ECT ,for each member.)

*** Father:**_____

_____

*** Mother:**_____

_____

*** Brother(s):**_____

_____

*** Sister(s):**_____

_____

Women Only:

***Please check what applies to you*:**

*** Last Menstrual Period: _____**

*** Irregular Periods?** Y / N *** Frequent Spotting?** Y / N *** Discharge?** Y / N

*** Are you Pregnant?** Y / N *** Are you nursing?** Y / N

*** Last pap: _____**

*** Last Mammogram: _____**

*** Last DEXA Scan: _____**

<u>Social History:</u>

Do you smoke: _Y_/_N_

If yes, how many Packs Per Day: _____

Since what age? _____

Full time Florida resident? _Y_/_N_

Alcohol: _Y_/_N_

Social _____Moderate ____Severe_____ None ____Past Problem

Number of Children Living: _____ Number of Pregnancies: _____

Number of Sons _____ Number of Daughters _____

Number of Brothers _____ Number of Sisters _____

Most Recent Occupation: _____

Exercise: _Y_/_N_ (if yes, form:_____)

Caffeine: _Y_/_N_ (if yes, form:_____)

Sexually Active: _Y_/_N_

Travel outside US: _Y_/_N_

Home Smoke Detector: _Y_/_N_

Pets: _Y_/_N_ (if yes, type:_____)

Name:_____ **DOB**:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use a "✓" to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself, or that you are a failure or having let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself				

Total : _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Mark which one applies):

Not difficult at all___ Somewhat difficult___ Very difficult___ Extremely difficult___

Tobacco Control

Name: _____ **Date:** _____

• Are you a:

___ current smoker ___ former smoker ___ never smoker

___ current every day smoker ___ current some day smoker

___ current status unknown ___ unknown if ever smoked

___ light tobacco smoker ___ heavy tobacco smoker

___ uses tobacco in other forms

- If 'current smoker' : When did you start smoking? _____
- If 'former smoker' : When did you start smoking? _____
- If 'former smoker' : When did you stop smoking? _____
- If 'current smoker' : How often do you smoke cigarettes? ___everyday ___some days, but not everyday
- If 'current smoker' : How many cigarettes a day do you smoke?

___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31 or more

- If 'current smoker' : How soon after you wake up do you smoke your first cigarette?

___ witihn 5min ___ 6-30min ___ 31-60min ___ after 60 min

- If 'current smoker' : Are you interested in quitting?

___ Ready to quit ___ Thinking about quitting ___ Not ready to quit

- If 'current some day smoker' : When did you start smoking? _____
- If 'current status unknown' : When did you start smoking? _____
- If 'former smoker' : How long has it been since you last smoked?

___ 1-3 months ___ < 1 month ___ 3-6 months

___ 6-12 months ___ 1-5 years ___ 5-10 years ___ > 10 years

- Additional Findings: Tobacco User

___Chain smoker ___Chews fine cut tobacco ___Chews loose leaf tobacco

___Chews plug tobacco ___Chews tobacco ___Chews twist tobacco

___Heavy cigarette smoker (20-39 cigs/day)

___Light cigarette smoker ((1-9 cigs/day)

___Moderate cigarette smoker (10-19 cigs/day)

___Pipe smoker ___Rolls own cigarettes ___Snuff user

___Trivial cigarette smoker (less than one cigarette/day)

___User of moist powdered tobacco

___Very heavy cigarette smoker (40+ cigs/day)

___e-Cigarette ___Aggressive non-smoker ___Current non-smoker

___Current non-smoker, but past smoking history unknown

___Does not use moist powdered tobacco ___Ex-cigar smoker

___Ex-cigarette smoker ___Ex-cigarette smoker amount unknown

___Ex-heavy cigarette smoker (20-30/day)

___Ex-light cigarette smoker (1-9/day)

___Ex-moderate cigarette smoker (10-19/day) ___Ex-pipe smoker

___Ex-trivial cigarette smoker (<1/day) ___Ex-user of moist powdered tobacco

___Ex-very heavy cigarette smoker (40+/day) ___Intolerant ex-smoker

___Intolerant non-smoker ___Never chewed tobacco

___Never used moist powdered tobacco ___Non-smoker for medical reasons

___Non-smoker for personal reasons ___Non-smoker for religious reasons

___Tolerant ex-smoker ___Tolerant non-smoker

CONSENT FOR TREATMENT

I hereby give consent to Bay Area Family Practice to provide whatever treatment the assigned providers may deem necessary to the patient named above.

I understand that I am responsible for payment to Bay Area Family Practice outpatient charges and that payment is due at the time of service. In the event of hospital admission, I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Bay Area Family Practice for Professional Physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

I hereby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Bay Area Family Practice furnished me by Bay Area Family Practice, I authorize any holder of my medical information about me to release to Bay Area Family Practice and its agents any information needed to determine these benefits payable for related services.

By signing below, I agree to be present for all scheduled appointments at Bay Area Family Practice. Failure to give 24-hour notice for cancelled appointments will result in a $50.00 charge.

Signature of Patient: _____

Today's Date: _____/ _____/ _____

Relationship to Policyholder: _____Family/Friends

Medical Information Release

I,_____, give permission to the staff of Bay Area Family Practice to discuss my medical information with the following people:

_____It **MAY** include information related to HIV/AIDS or STDs
_____It **MAY NOT** include information related to HIV/AIDS or STDs

_____It **MAY** include information on my mental health
_____It **MAY NOT** include information on my mental health

_____It **MAY** include information on drug or alcohol abuse
_____It **MAY NOT** include information on drug or alcohol abuse

Name:	Relationship:
1._____	_____
2._____	_____
3._____	_____
4._____	_____

This request will remain in effect until revoked by the above named person in writing.

_____ _____

Patient Signature Date

_____

Witness

Notice of Privacy Practices

The Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or discuss for treatment, payment, or health care operations. You may ask us not to use or disclose any part of your PHI and by law we must comply when the PHI pertains solely to a healthcare item or service which the health care provider involved has been paid out of pocket in full. You also have the right to request a limit on the PHI we disclose about you to someone else involved in your care or payment of your care. Your request must be made in writing to our HIPPA Compliance Officer with specific instructions. If we agree to the restriction, we may only be in violation of that restriction for emergency treatment purposes. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

The Right to Get Notice of a Breach: You have the right to be notified upon a breach of any unsecured PHI. *The Right to Request Amendments:* If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information, a request and the reason for the requested amendment must be made in writing to the HIPPA Compliance Officer at the information at the end of this Notice. In certain cases, we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy.

The Right to an Accounting of Disclosures: You have the right to receive an accounting of all disclosures except for disclosures pursuant to an authorization, for purposes of treatment, payment, health care operations; required by law, that occurred six years prior to the date of your request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically. The first accounting of disclosures in any 12month period will be free. Any additional request within that same time period we may charge reasonable costs. You may withdraw or modify your request before the costs are incurred.

The Right to Request to Receive Confidential Communications: You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

Complaints: You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPPA compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you know of or suspected the violation. There will be no restriction against you for filing a complaint. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human services, 200 Independence Ave, S.W. Washington, D.C. 20201. Call (202) 619-0257 (or toll free (977) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hippa/, for more information. There will be no retaliation against you for filing a complaint.

If you have any questions in reference to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at the information at the end of this Notice. You have the right to request a paper copy of this letter at any time. Please sign below to acknowledge you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Patient Signature Date

Acknowledgement of Receipt of Privacy Practices Notice

I acknowledge that I have read and/or been provided with a copy of the Bay Area Family Practice "Notice of Privacy Practices".

I give permission for Bay Area Family Practice staff to leave appointment reminder notices on my answering machine or with a member of my household. **Please Circle:** YES NO

I give permission for Bay Area Family Practice staff to leave a brief medical message(ex. Please call the office to discuss your test results) on my answering machine or with a member of my household.

Please Circle: YES NO

_____ _____

Patient Signature Date

_____

Patient Printed Name

_____ _____

Witness Date

Our Financial Policy

_____ _____

Patient Name Date of Birth

If you have Medicare:

We are happy to accept assignment on all Medicare claims. Medicare pays 80% of the allowable amount after your $_____ deductible has been met. Please understand that you are responsible for payment of the 20% coinsurance and the deductible amount. Additionally, if you have supplemental coverage, we will be your supplemental insurance as a courtesy to you. If for any reason your supplemental coverage does not pay, we must request payment directly from you.

If you have other insurance coverage:

We will bill your insurance company for you, and request payment to be sent directly to us. We will make all reasonable attempts to collect appropriate payment from your insurance company, but payment in full is required within 60 days of the date of service. Please understand that you are responsible for payment of any coinsurance, deductible, and any charges not covered by your insurance.

Financial Agreement:

Please Initial

_____: I understand and agree that, regardless of my insurance status, I am fully responsible for the balance of my account for any professional services rendered to me by Bay Area Family Practice,
Physicians and staff. I understand and agree that unless other payment arrangements are made, payment is expected at the time of service. Failure to make proper and timely payment on my account could result in my account being referred to an outside source for collection action, and I will be responsible for any additional charges incurred.

_____: If my account is turned over to a collection agency, I will have thirty (30) days from the date my account is turned over to select a new primary care physician.

No Show Policy: (Please Initial)

_____: I understand and agree that if I fail to cancel an appointment within 24 hours' notice, I will be charged $50 for that visit. The full amount due for the missed appointment must be received prior to my next scheduled appointment. Failure to cancel three appointments will result in dismissal from the practice for noncompliance.

Consent for Treatment: (Please Initial)

_____: I consent to the provision of examinations, treatments, medical, and laboratory procedures, drugs and supplies to the patient, as ordered or requested by the patient's physician(s) and acknowledges that no guarantee has been made as to the results of such treatment, procedures, or examinations. This also includes injections of medication and/or vitamins.

_____ _____

Patient's Signature Today's Date