IN HEALTH FAMILY MEDICINE

NEW PATIENT REGISTRATION

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| NAME: |  | Date of Birth: |  |
| ADDRESS: |  | GENDER: M / F | AGE: |
| SS #: | HOME #: | CELL #: |  |
| IS IT OKAY TO LEAVE A MESSAGE WITH THE NUMBERS PROVIDED? (please circle yes or no for each.) | HOME: YES/NO | CELL: YES/NO |
| EMAIL ADDRESS: |
| EMPLOYER: |  | PHONE #: |  |
|  |  |  |  |
| FAMILY MEMBERS SEEN HERE: |  |  |  |

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|  |  | **INSURANCE INFORMATION** |  |  |  |
| **PRIMARY INSURNCE:** |  |  |  |  |  |
| SUBSCRIBER: |  | DOB: | ADDRESS: |  |  |
| PHONE #: |  | PATIENTS RELATIONSHIP TO SUBSCRIBER: |  |  |  |
| POLICY #: |  | GROUP #: |  | CO PAYMENT: |  |

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| **SECONDARY INSURNCE:** |  |  |  |  |  |
| SUBSCRIBER: |  | DOB: | ADDRESS: |  |  |
| PHONE #: |  | PATIENTS RELATIONSHIP TO SUBSCRIBER: |  |  |  |
| POLICY #: |  | GROUP #: |  | CO PAYMENT: |  |

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|  | EMERGENCY CONTACT/ PERMISSION TO SPEAK WITH |  |  |
| NAME: | RELATIONSHIP: |  | NUMBER: |
| NAME: | RELATIONSHIP: |  | NUMBER: |

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 In Health Family Medicine to release any information required to process my claims.

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| Patient Signature: | Date: |
|  |  | **IMMUNIZATION** |  |  |  |
| Chickenpox or Shot |  | Yes  |  | No | Date: |
| Hep B series |  | Yes |  | No | Date: |
| Influenza Shot |  | Yes |  | No | Date: |
| Pneumonia Shot |  | Yes |  | No | Date: |
| Rubella Shot or Blood Test |  | Yes |  | No | Date: |
| Tetanus Shot |  | Yes |  | No | Date: |

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|  |  | **FAMILY HISTORY (please note if maternal or paternal relative)s** |  |  |
|  | AGE | IF DECEASED, AGE & CAUSE | MEDICAL ISSUES |  |
| Father: |  |  |  |  |
| Mother: |  |  |  |  |
| Brother/Sister |  |  |  |  |
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| Children: |  |  |  |  |
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|  | PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE |  |  |  |
|  | CONDITION | WHO: |  | CONDITION | WHO |
|  | Alcohol/Drug abuse |  |  | High Cholesterol |  |
|  | Allergy Asthma |  |  | HIV/AIDS |  |
|  | Arthritis |  |  | Kidney Disease |  |
|  | Bleeding Disorder |  |  | Mental Illness |  |
|  | Cancer |  |  | Migraine Headaches |  |
|  | Diabetes |  |  | Sickle Cell Condition |  |
|  | Epilepsy/Seizures |  |  | Stroke |  |
|  | Glaucoma |  |  | Suicide/ Depression |  |
|  | Heart Disease |  |  | Thyroid Disease |  |
|  | High Blood Pressure |  |  | Other |  |

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|  |  | **SOCIAL HISTORY** |  |  |
| Current Status |  |  |  |  |
| Whom do you reside with? |  |  |  |  |
| Highest Education achieved? |  |  |  |  |
| Occupation |  |  |  |  |

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|  |  |  | PERSONAL HISTORY |  |
| **Questions for Woman:** |  |  |  |  |  |  |  |
| Age periods Began  |  | How often: |  | Date of last period: |  |  |  |
|  |  |  |  |  |  |  |  |
| Currently Pregnant? |  | Yes |  | No |
| Vaginal Discharge? |  | Yes |  | No |
| PMS? |  | Yes |  | No |
| Menopause? |  | Yes |  | No |
| Unexplained Vaginal Bleeding? |  | Yes |  | No |
| Discharge from Nipples? |  | Yes |  | No |
| Skin Changes in Breasts? |  | Yes |  | No |

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| **Pregnancies:****(woman Only)** |
| Total # of Pregnancies |  | Full Term: |  |
| Date of last Pap smear |  |
| Miscarries  |  |
| Abortions |  |
| Premature Births |  |
| Tubal |  |
| Date of Last Mammogram |  |

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| **MEN ONLY** |
| Prostate Trouble |  | Yes |  | No |
| Discharge from Penis |  | Yes |  | No |
| Sore on Penis |  | Yes |  | No |
| Do you examine you testicles |  | Yes |  | No |

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| **Men and Woman** |  |
| What kind of Birth control/Protection do you and your partner use? |  |  |
| What is your sexual orientation? |  |  |  |
| Do you use sunscreen |  | Yes |  | No | Do you floss regularly? |  | Yes |  | No |
| Do you wear a seatbelt |  | Yes |  | No | Do you where dentures? |  | Yes |  | No |
| Any guns/weapons in your home? |  | Yes |  | No | Do you where glasses? |  | Yes |  | No |
| When was you last dental visit? |  | When was your last eye exam |  |
| Have you had a colonoscopy?  |  | If so when was your last? |  |

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| **Diet, Exercise & Habits** |
| Do you follow a specific Diet? |  | If yes, Please explain |  |
| What kind of exercise do you do and how often? |  |
| Current weight? |  | Desired? |  | One year ago? |  |

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| **Tobacco & Alcohol Use** |
| Do you Smoke? |  | What type? |  | How long and often |  |
| Have your tried quitting? |  | When? |  |
| Do you drink Alcohol? |  | How many per week |  |
| Is anyone concerned about your drinking? |  |
| **Allergies** |
| Do you have any allergies? |  |
| If yes, please list any allergies to medications or other substances |  |

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| **Surgery/Hospitalization** |  |
| *Date* | *Reason* |  |
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| **Medical Concerns** |
| List all current medical concerns |
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| **Medications** |
| Medication | Dose |
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| What is your preferred Pharmacy? |  |

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE

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| Past | Present |  | Past | Present |  |
|  |  | Abnormal Electrocardiogram |  |  | Gallstones |
|  |  | Abnormal Pap |  |  | Glaucoma |
|  |  | AID/HIV |  |  | STD |
|  |  | Alcohol or Drug Abuse |  |  | Skin Growth |
|  |  | Allergies or Hay Fever |  |  | Hearing problems |
|  |  | Anemia (Low Iron) |  |  | Heart Attack |
|  |  | Ankles Swell Frequently |  |  | Heart Murmur |
|  |  | Anxiety or Panic Attacks |  |  | Hepatitis or Cirrhosis  |
|  |  | Arthritis or Gout |  |  | Herniated or Ruptured Disc |
|  |  | Asthma |  |  | High Blood Pressure |
|  |  | Frequent Backaches |  |  | Hodgkin’s Disease, Lymphoma, leukemia |
|  |  | Bladder Infection |  |  | Intolerance to Dairy or Fats |
|  |  | Blood Clots or Bleeding prob. |  |  | Irregular Heartbeat |
|  |  | Blood in bowel movement |  |  | Irritable Bowel Syndrome |
|  |  | Blood transfusion |  |  | Kidney Disease |
|  |  | Boils or Cysts |  |  | Lung Problem |
|  |  | Bone or Joint Disease |  |  | Lupus |
|  |  | Bowel or Colon Disease |  |  | Malaria |
|  |  | Breast Lumps |  |  | Seizures, convulsions, Epilepsy  |
|  |  | Bronchitis (recurrent)  |  |  | Meningitis |
|  |  | Bruise easily |  |  | Migraines  |
|  |  | Bursitis or Tendonitis |  |  | Muscle Disease or Weakness |
|  |  | Cancer |  |  | Pancreatitis  |
|  |  | Chest Pain |  |  | Phlebitis |
|  |  | Chills or Night sweats |  |  | Pleurisy |
|  |  | Cholesterol |  |  | Pneumonia  |
|  |  | Chronic Cough |  |  | Polio |
|  |  | Colitis |  |  | Sickle Cell Disease |
|  |  | Color-Blindness |  |  | Skin Disease  |
|  |  | Concussion |  |  | Stomach Pain |
|  |  | Constipation |  |  | Swelling in the Joints |
|  |  | Depression or Suicide |  |  | Thyroid Disease |
|  |  | Diabetes  |  |  | Tremors or Shaking |
|  |  | Difficulty Swallowing |  |  | Tuberculosis |
|  |  | Dizziness |  |  | Ulcer Disease |
|  |  | Emphysema |  |  | Unexpected Weight loss |
|  |  | Excessive Stress |  |  | Urinate frequently at night |
|  |  | Frequent Cold or Sinus Issues |  |  | Varicose Veins |
|  |  | Frequent Earaches  |  |  | Venereal Disease |
|  |  | Frequent or painful urination |  |  | Wheezy or Whistling Chest |
|  |  | Frequent sore throats |  |  | Yellow Jaundice |
|  |  | Severe nose bleeds |  |  | Gallbladder disease |

IN HEALTH FAMILY MEDICINE

FINANCIAL/ ATTENDANCE POLICIES

**INSURANCE:**

You are responsible for providing current proof of medical insurance, and an insurance card must be presented at the time of your visit in order to be seen. Incorrect information will result in nonpayment to IN HEALTH FAMILY MEDCINE, and you will be considered a “self-pay” patient. If your insurance has not paid after 45 days from the date of service, it is your responsibility to contact your insurance and notify us of the problem After 60 days of non-payment, the balance will be transferred to you for payment in full. Any balance over90 days will be considered non-payment, and a 30 day demand for payment in full letter will be issues. At that point requests for appointments and prescription refills will not be honored, and your account will be assigned to a collection agency. You be responsible for any fees charged by the collection agency.

**Co-payments and Deductibles:**

Co-payments listed on the front of your insurance card will be collection upon CHECK-IN, prior to seeing the doctor. If you have a balance from your previous visits, that amount is also due upon CHECK-IN. If circumstances prevent you from paying a balance over 60 days, we reserve the right to reschedule your appointment. In reference to deductibles: Until you meet your annual deductible, the insurance company will not pay us and payment is due from you upon receipt of our deducible notice. We accept Cash, Check, and Credit Card payments.

**Missed Appointments:**

Failure to keep a scheduled appointment without 24 business hours’ notice of cancellation denies access to other patients wishing to be seen and will result in a $50.00 no show/cancellation fee. Courtesy reminder calls are not guaranteed and are not valid excuses to miss appointments. We recognize many inconveniences come up unexpectedly, but please do your best to keep your scheduled appointments. After 2 no call/no show appointments, you may be discharged from In Health Family Medicine.

**Prescription Refills:**

We require 72 BUSINESS hours to process a refill request. In the event you are unable to provide In Health Family Medicine 72 hours’ notice to fill a script, you will be subject to a $10.00 emergency refill fee. There are no exceptions. Please plan accordingly.

**Attendance:**

In Health Family medicine requires all patients to have yearly annuals and be followed up regularly. Any patient on medications are required to be seen every 3-6 months depending on the medication. Any patient who refuses to comply with this policy may be discharged for Noncompliance.

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Patient Signature Date