Christian Family Medicine & Pediatrics

ADULT PATIENT REGISTRATION FORM

Please Print Clearly

Patient Information

Legal Name____ Birth/Maiden Name_____________________

Gender: M F *(Circle One)* SSN________________ Marital Status_____________ Date of Birth______________

Race: African American Asian Caucasian Other *(Circle One)* Ethnicity: Hispanic Not Hispanic Preferred Language__________

Primary Provider_________________ Religion _____________ Dominant Side: Right Left Ambidextrous *(Circle One)*

Address____ City/ State/ Zip _________________________

Home Phone_____________Cell Phone_____________Work Phone___________Ext _____

Email address:_______________________________

Preferred Contact Method: Phone Text Mail Email *(Circle One)* Preferred Reminder Method: Cell Home Office Mail Email

Consent: Immunization Sharing Yes No *(Circle One)* Health Information Exchange Yes No *(Circle One)*

Emergency Contact: __________________Contact #_______________Relationship:_____________

Pharmacy of Choice___________________________ City______________ Phone:_____________

Patient Employer______________________FT/ PT Phone:_____________Student: No Yes, FT PT*(Circle One)*

Insured Information

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

Insured Name_____________________________ Date of Birth___________ Gender: M F *(Circle One)*

SSN ______________________ Marital Status___________ Phone__________

Address______________________________________ City/State/Zip__________________________

Insurance Information

Primary Insurance

Ins. Co______________________________ Effective Date ____________ Copay Amount $_________

Policy # __________________________________ Group/ Plan # _____________

Policy Holder's Name____________________________ Date of Birth _________ SSN________________

Address_______________________________________ City/ State/ Zip _________________________

Phone # __________________________________ Relationship to Patient ________________

Secondary Insurance

Ins. Co______________________________ Effective Date ____________ Copay Amount $_________

Policy # __________________________________ Group/ Plan # _____________

Policy Holder's Name____________________________ Date of Birth _________ SSN________________

Address_______________________________________ City/ State/ Zip _________________________

Phone # __________________________________ Relationship to Patient ________________

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. Including but not limited to: FMLA, Disability, Adoption forms

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 understand that Christian Family Medicine, Inc. is a PCMH facility and I have been given information to explain the program.

__ I understand that I have been made aware of CFM&P Notice of Privacy Practices.

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

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Patient Disclosure Authorization Form

Christian Family Medicine Inc. has provided me notification of their Privacy Practice for protected health information. I authorize Christian Family Medicine, Inc. the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

□ Spouse ____________________________________

□ Child(ren)__________________________________

□ Other ______________________________________

□ Other ______________________________________

□ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:
- □ my home
- □ my work
- □ my cell number: ____________________________

If unable to reach me:
- □ you may leave a detailed message
- □ please leave a message asking me to return your call
- □ do not leave a message

____ ____________________
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 & Pediatrics				
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.

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Comprehensive Adult New Patient Health History Questionnaire

Current **Problems**: ____

____

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

____

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

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

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

____

Past Medical History, Family History & Social History

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

____

PREVENTIVE TESTING/ IMMUNIZATIONS: (please provide date if completed)

□ Colonoscopy: ____ □ Stress Test: _____ □ Eye Exam: _____ □ Wear contacts or glasses □ Wear hearing aids □ Dental Cleaning: ______

Please list (or provide a printed record) of immunizations and provide date of immunization.

Do you have any metal in your body? If yes, please explain. ____

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: _____
Menstrual History: Age period started: _____ Age period stopped: _____ Hysterectomy Yes No *(Circle One)*
Please list your current method of birth control ______________________________

Men Only: (Please check if you currently experience any of the following)
□ Prostate Issues □ Erectile Dysfunction □ Impotence □ Other: ___________________________________

MEDICAL HISTORY: Please indicate who 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.
Please indicate if the condition is Current (C) or Past (P) under the correct column for yourself.
Adopted? □ No □ Yes If adopted and you do **NOT** know your family history skip the Family History Section and continue to Health Issues.

	YOURSELF		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											
	C	P									
No significant history known											
Hypertension – high blood pressure											
Hyperlipidemia – high cholesterol											
Diabetes Type I/ II (please indicate)											
Cancer, (please specify type)											
Alcoholism/ Drug Abuse											
Allergies											
Alzheimer's											
Anemia											
Anxiety											
Asthma											
Autoimmune disease											
Bleeding/ Clotting Disorder											
Blood Transfusion											
Colon Polyp											
Depression											
Diverticulitis											
Emphysema (COPD)											
Eye Disorders (Cataracts, Glaucoma, Macular Deg)											
Genetic Disorder (Please Explain)											
GERD											
Heart Disease (CHF) / Attack											
Hepatitis											
Hypothyroidism/ Thyroid Disease											
IBS/ IBS-D											
Kidney Disease / Failure											
Liver Disease											
Migraines											
Osteoporosis											
Seizures											
Sleep Apnea											
Stroke											
Other:											
Other:											

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:			

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

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