Richard A. Kelly, MD

PATIENT REGISTRATION

(Please be as complete as possible)

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

SSN_____-_____-_____ Date of Birth: _____ Gender: ____ Marital Status: **S M W D**

Preferred Language: □ English □ Spanish Other _____ □ Declined

Race: (check one) □ American Indian □ Asian □ Native Hawaiian □ African American
□ White □ Hispanic □ Other □ Declined

Ethnicity: (check one) □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Pharmacy (name/addr/phone):_____

Employer: _____

Emergency Contact Name: _____ Relationship:_____

Emergency Contact Phone #: _____

Email Address: _____

Home Phone #: _____ Cell: _____Work: _____

Communication Preferences:

Do you authorize our office to leave messages at: HOME yes/no WORK yes/no CELL yes/no

Enable access to online Patient Portal for messaging and viewing test results? □ **Yes** □ **No**

Automated Communication Preferences (check boxes):

Health Notifications (recommend all)	□ Email	□ Phone	□ Text Message
Appointments (recommend all)	□ Email	□ Phone	□ Text Message
Announcements	□ Email	□ Phone	□ Text Message
Billing (recommend all)	□ Email	□ Phone	□ Text Message

Do not place any automated phone calls or emails □

_____ _____

Patient's Signature (Responsible Party) Date

Last Name: _____ First Name: _____ Middle Initial: _____

Responsible Party if Minor

Name: _____ DOB: _____ Phone: _____

Address: _____City/State/Zip: _____

SSN: _____-_____-_____

Insurance Information

Primary Insurance: _____ Phone: _____

Name of Insured: _____ SSN of Insured: _____-_____-_____

Date of Birth of Insured: _____ Relationship to Insured: _____

Secondary Insurance: _____ Phone:_____

Name of Insured: _____ SSN of Insured: _____-_____-_____

Date of Birth of Insured: _____ Relationship to Insured: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the clinic/physician. I understand that I am financially responsible for any balance. I also authorize Richard A Kelly, MD PA or insurance company to release any information required to process my claims. I accept full responsibility for any reasonable attorney's fees, court costs and legal fees associated with the collection of this account if there is a default in payment. I understand that Richard A Kelly, MD PA utilizes family billing; therefore the charges associated with any visit may be viewed by other family members. I have been offered a copy of Richard A Kelly, MD PA's Notice of Privacy Practices.

_____ _____

Patient's Signature (Responsible Party) Date

Richard A Kelly, MD, PA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Richard A Kelly, MD, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Richard A Kelly, MD, PA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Richard A Kelly, MD, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard A Kelly, MD, PA Privacy Officer at 210 Goodman Rd E, Southaven, MS, 38671.

With this consent, Richard A Kelly, MD, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Richard A Kelly, MD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, any mail pertaining to my clinical care, including laboratory results as long as they are marked Personal and Confidential.

With this consent, Richard A Kelly, MD, PA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, any mail pertaining to my clinical care, including laboratory results. I have the right to request that Richard A Kelly, MD, PA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Richard A Kelly, MD, PA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Richard A Kelly, MD, PA may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Patient Name:_____ DOB:_____

Authorization to provide treatment
Insurance assignment and release

I hereby authorize Richard A. Kelly, MD. or any other physician authorized by him, to provide such medical services, either regular or emergency, as may be determined by the physician to be in my best interest (or the best interests of my dependent if I am signing as a parent or guardian).

I hereby authorize Richard A. Kelly, MD. or its agents to furnish information to Medicare, insurance carriers or other third-party payors concerning my illness and treatments. I hereby assign to the Physician all payments for medical services rendered to myself or my dependents.

I understand that unless other arrangements are made by me or my insurance company, I am expected to pay at the time of service. Cash, local checks, Visa or Mastercard will be accepted.

In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within thirty(30) days from the date billed unless there are other agreements between me or my insurance company and I agree to pay all collection costs including, but not limited to court costs, witness expenses and reasonable attorney's fees if it becomes necessary to turn this account over to an outside party for collection.

These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to Richard A. Kelly, MD.

Patient/Responsible Party:_____

Date:_____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Name_____ Phone_____	

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____