Family Centered Medicine, Inc.
NEW PATIENT REGISTRATION

_____

LAST NAME **FIRST NAME** **M.I**

DATE OF BIRTH: _____ **GENDER:** _____

BIRTH PLACE: _____ **SSN:** _____

ADDRESS: _____
(City / State / Zip Code)

PHONE NUMBER: _____

EMPLOYER: _____ **PHONE #:** _____

***FULL TIME** ____ ***PART TIME** ____

STUDENT / SCHOOL: _____

MARITAL STATUS: S / M / W / D **SPOUSE NAME:** _____

PRIMARY INSURANCE:

INSURANCE COMPANY: _____

ID NUMBER: _____

GROUP NUMBER: _____

EMERGENCY CONTACT

NAME: _____ **PHONE #:** _____

RELATIONSHIP: _____

_____

PRINT **SIGNATURE** **DATE**

PATIENT HEALTH HISTORY

Name _____ **Date of Birth** _____/_____/_____

Nickname _____

Medical History

Have you had any ongoing illness or injuries (Such as diabetes, heart attack, high blood Pressure, asthma, car accident)? _____

_____

_____

Have you had any **OPERATIONS**? What Surgeries have you had done? _____

_____

_____

What **DOCTORS** / **COUNSELORS** have you Seen in the last 5 years? What was the reason For the office visit?

_____ _____

_____ _____

_____ _____

_____ _____

When was your last routine visit with:

EYE DOCTOR (Name) _____

(Date) _____

DENTIST (Name) _____

(Date) _____

FOR WOMEN

*Are you taking contraception? Y or N

*Are you pregnant? Y or N

*Are you nursing? Y or N

Number of Pregnancies _____

Living Children _____

Abortions _____ **Miscarriages** _____

Prescriptions you are taking:

_____

_____

_____

_____

_____

Non-Prescriptions vitamins, herbs, OTC drugs:

_____

_____

_____

ALLERGIES

Are you allergic to any of the following? What reactions/side effects take place?

Y or N TETRACYCLINE

Y or N PENICILLIN

Y or N LATEX

Y or N ASPIRIN

Y or N ERYTHROMYCIN

Y or N CODEINE

Y or N ANESTHETICS

Y or N SULPHA

Others: _____

_____

IMMUNIZATIONS (Please List Dates)

Tetanus _____ Measles _____

Influenza _____ Pneumonia _____

Hepatitis A _____ TB Test _____

Hepatitis B_____

FAMILY HEALTH HISTORY

	NAME	AGE	DISEASES
FATHER			
MOTHER			
BROTHERS			
SISTERS			

SPOUSE / PARTNER			
CHILDREN			

SOCIAL HISTORY

True Not

_____ _____ I SMOKE or use tobacco cigarettes cigars pipe chew (circle products used)
How many years? _____ How many packs per day? _____

_____ _____ I DRINK alcohol How many drinks per week? _____

_____ _____ I use DRUGS or have used them in the past

_____ _____ My CHOLESTEROL is too high

Who lives in your home? _____

Do you have any pets? _____

What do you do for fun or relaxation? _____

Patient's PRINTED Name: _____ **Date:** _____

Patient's SIGNATURE: _____

Family Centered Medicine, Inc.

WWW.FAMILYCENTEREDMEDICINE.COM

PATIENT AGREEMENT

***CANCELLATION/NO SHOW POLICY**

We understand that there are times when you must miss an appointment due to emergencies, work or family obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a needed appointment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $50 fee; this will not be covered by your insurance company.

***SCHEDULED APPOINTMENTS**

We are aware that delays can happen, however we try to keep all of our patients and our providers on time.

If a patient arrives 15 minutes or more past their scheduled time we will have to RESCHEDULE the appointment.

***ACCOUNT BALANCES**

If you have any questions about your bill or would like to discuss a payment plan, please call our Billing Consultant: Dave Golias 720-949-6400.

Patients with balances over $100 must make a payment arrangement or pay in full account balance prior to future appointments being made.

***INSURANCE**

The patient accepts primary responsibility for determining if "Peter Prutch" or "Family Centered Medicine" is in-network for their chosen plan. If a claim processes as out-of-network, the patient agrees to current self pay rates.

***LABORATORY BALANCE (BLOOD WORK)**

PLEASE be advised that any laboratory billing is done directly with LABCORP OR QUEST. Billing balances will depend on which lab your insurance is contracted with. We do not do any lab billing.

_____ _____ _____

Patient Signature **Patient Printed Name** **Date**

Family
Centered
___Medicine, Inc._____www.familycenteredmedicine.com

HIPAA NOTICE ACKNOWLEDGEMENT

The Practice of Family Centered Medicine, Inc. is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examinations, and test results, diagnoses and treatment protocols. It may also include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996(HIPAA), to use and disclose your PHI for the purposes of treatment, payment and health care operation without your written authorization.

We will use your PHI during the course of your treatment if the physician determines we will need to consult with a specialist in another area. He will share the information with the specialist and obtain their input. We will also use your PHI to contact you by phone, if we need to speak to you about a medical condition, or remind you of a medical appointment. We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. You may revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

You have the right to receive Notice of Privacy Practices for Protected Health Information from our office or visit our website at www.familycenteredmedicine.com. I acknowledge that I have been given the option to receive a copy of the Notice of Privacy Practices for the practice of Family Centered Medicine, Inc.

Print Name: _____

Signature: _____ **Date:** _____

Phone Number: _____ **LEAVE VOICEMAIL: Y N**

E-Mail: _____