

Patient Registration Form (eCW)

(Please Print)

PATIENT INFORMATION

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) (First) (MI) Previous Name

Mailing Address

City, State ZIP

Home Phone Cell No. Work Phone Ext.

Primary Care Provider (PCP) Referring Provider

Rendering Provider Name (this practice) E-Mail Address:

Date of Birth MM/DD/YYYY Sex F - Female M - Male Transgender

Race American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number Employer Name

Employment Status 1 - Full-Time 2 - Part-Time 3 - Not Employed 4 - Self-Employed 5 - Retired 6 - Active Military

Student Status F - Full-Time Student P - Part-Time Student N - Not a Student

Emergency Contact Last Name First Name

Phone Number Do you have a living will? Yes No

Emergency Contact Relationship to Patient Guardian

Address Line 1

City, State ZIP

Home Phone Work Phone Ext.

Referring Provider Name

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self Check here if information is same as patient

Responsible Party Name (Last) (First) (MI)

Relationship to Patient Date of Birth MM/DD/YYYY

Social Security Number Telephone

E-Mail Address Sex F - Female M - Male

Mailing Address

City, State ZIP

Employer Employer Phone Number

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number

Name of Insured Patient Relationship to Insured

Subscriber ID (Policy Number) Group ID Copay Amount

Effective Date Termination Date Date of Birth MM/DD/YYYY

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature Date

CONSENT FOR TREATMENT:

I consent to services, treatment, and diagnostic procedures including, but not limited to, medications, lab tests, and other studies, which may be ordered by my physician, and consultants as selected by my physician at Bossier Family Medicine, LLC. I have the right to ask questions and receive information about any services that I may receive.

INJECTIONS:

I understand if I receive any medications by injection there are risks associated. These risks include pain, scarring, bleeding, infection, and possible dimpling of the skin. By signing, I am stating that I understand these risks and consent for treatment in this manner. I also understand not all insurance carriers pay for injectable medications as treatment. In the event my insurance does not pay for steroids, antibiotics, medications for nausea, or any other medications, I will be billed in full.

FINANCIAL POLICY:

It is our policy to require payment of all charges at the time of service. As a courtesy to you, we file the bill with most insurance carriers as long as you have provided us with all the policy numbers, addresses, your place of employment, and any other pertinent information. By signing this consent, you assign all rights, title, and interest. You authorize direct payment to Bossier Family Medicine, LLC of any insurance benefits or benefits under the Social Security Act for services. You are responsible for all deductibles and charges not covered by insurance at the time of visit or service.

RELEASE OF INFORMATION:

I acknowledge, that to the extent necessary, to determine liability for payment or to obtain reimbursement, Bossier Family Medicine may disclose my records to any person Social Security Administration, insurance or benefit payer, healthcare service or plan, or worker's compensation carrier, which is or may be, liable for all or any of the charges. I also give my permission for both personal and medical information to be released to other treating physicians, healthcare providers, and audit committees for the purpose of quality improvement and applicable state and federal agencies.

Patient / Responsible Party

Date

Bossier Family Medicine

PATIENT PORTAL REQUEST FORM

The Patient Portal is a secure online access to a portion of your “chart” in our office. Due to privacy issues once you complete the form we ask that you return the form in person. We will need a copy of your picture ID to verify you are the correct person requesting this information. You must complete a form for each patient you are requesting portal access on.

Patient Name: _____

(if patient is under the age of 18 parent/guardian must be listed and a copy of their picture ID will be obtained)

Patient’s Date of Birth: _____

Parent/Guardian: _____

E-mail Address: _____

(please print and use the proper upper/lower case when needed – this is where replies to your request will be sent)

Phone Number: _____

(This is needed in case your email does not go through)

Do you want a custom user name?

(user name is typically first name last name and year of birth, i.e. JOHNSMITH1978)

YES NO

requested name

By signing and dating this form, I am authorizing Bossier Family Medicine to create a patient portal username and password for the patient listed above. I understand that this information will be emailed to me within 2 business days at the email I have given above.

Signature: _____ **Date:** _____

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____