Mission Family Practice

Patient Registration

Today's date_____

Patient Information/Please Print

NAME:_____

Social Security No:_____ Birthdate:_____ Sex: ___Male ____ Female

Home Address:_____

City_____State_____Zip_____Home Phone:_____

Cell Phone:_____E-mail :_____

Primary Language Spoken:_____

__Single ____Married ____Domestic Ptr ___Separated ___Divorced ____Widow

Race: o American Indian or Alaskan o Asian o Black or African American

oNative Hawaiian or Pacific Islander o White o Unknown/Not Reported

Ethnicity: o Hispanic or Latino o Not Hispanic or Latino o Unknown/Not Reported

Occupation:_____Employer Name:_____

Employer Address:_____Phone:_____

Financially Responsible Party/Insured Subscriber

Name:_____Birthdate:_____

Address:_____

Home number:_____Cell Number:_____

Relationship to Patient:_____

Insurance and Payment Information

o Patient Covered by insurance o Cash Patient

Primary Insurance Co _____ ID number _____

Group Number_____ Copay$_____

Subscriber's Full Name:_____ Birthdate:_____

Patient's relationship to Subscriber: ___self ___Spouse __child __other:_____

Secondary Insurance Co_____ID number_____

Group#_____Co-pay_____

Subscriber's Name:_____Birthdate:_____

Emergency Contact Information

Full Name:_____

Relationship to Patient_____

Home Phone:_____Cell Phone:_____

Do you have an Advance Directive? (these allow a patient to state choices for healthcare and name someone to make choices if he or she is unable to do so) Please circle all that apply.

- o **None**
- o **Advanced Health Care Directive**
- o **POLST** (physician orders for Life-sustaining treatment)
- o **Living Will**

Treatment of Minor Consent/Authorization

I authorize Mission Family Practice to render medical or surgical treatment to the above named minor of whom I am the parent or legal guardian.

Signature of Parent/Legal Guardian:_____Date:_____

Assignment of Benefits/Financial Agreement

I, the undersigned, assign all medical or surgical benefits from the insurance carrier(s) listed above directed to Mission Family Practice for services rendered to me (or my dependents). I understand that I am financially responsible for all charges whether or not they are paid by my insurance.

Mission Family Practice may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature:_____Date:_____

FAMILY PRACTICE/INTERNAL MEDICINE HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY

_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date:_____
- ☐ Flu Shot Date:_____
- ☐ Gardasil/HPV Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Meningococcus Date:_____
- ☐ MMR (*Measles, Mumps, Rubella)* Date:_____
- ☐ Pneumonia Date:_____
- ☐ Tdap (*Tetanus and pertussis)* Date:_____
- ☐ Tetanus Date:_____
- ☐ Zostavax (*Shingles)* Date:_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal

Last Mammogram Date _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ births: _____

miscarriages: _____ abortions: _____

☐ Cesarean sections If yes, then number: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active

  Current sexual partner is ☐ Female ☐ Male

  Do you use condoms? ☐ Yes ☐ No

  Other Birth control method used:_____

  ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.				
2.				
3.				
4.				

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Occupation
_____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level
- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Caffeine
☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? _____

Alcohol
Do you drink alcohol?
☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco
Do you use tobacco?
☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
- ☐ Cigarettes - _____pks./day
- ☐ Chew - _____/day
- ☐ Cigars - _____/day
- ☐ # of years_____

Or year quit _____

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

_____

Parent, Guardian, or Caregiver Signature

_____

Date

CONFIDENTIAL COMMUNICATION REQUEST AUTHORIZATION

Many of our patients allow family members, such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the paitent's consent. If you wish to have information released, you must complete and sign below.

I authorize the use of the following means of communication for information related to my personal health, medical treatment, or payment of treatment/billing information.

PLEASE SELECT ALL THAT APPLY:

_____Phone Phone numbers: Home_____

Cell_____

Work_____

_____You have my consent to leave a message regarding my treatment on voicemail.

_____Do not leave a message regarding my treatment on my voicemail.

_____Written Communication to mailing address:_____

Please specify the person(s) allowed to receive medical information:

_____	_____	_____
Name	Phone number	Relationship
_____	_____	_____
Name	Phone number	Relationship
_____	_____	_____
Name	Phone number	Relationship

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

I have the right to revoke this consent in writing.

Signature:_____Date of Birth:_____Date_____

Print Name:_____

MISSION FAMILY PRACTICE

PATIENT FINANCIAL POLICY AGREEMENT

Dear Patient,

This letter sets forth our office financial payment policy. Thank you for choosing us as your health care provider. We are committed to providing you with the best possible care.

We accept Cash, Checks, Visa, and MasterCard. There is a $35.00 service charge for returned checks and may be subject to additional collection fees and bank costs. Full payment is due at the time of service. As a courtesy to you, we will bill your insurance. Any portion of the balance that is not paid by the insurance company due to patient copays or deductible amounts, non-covered services, deemed by the insurance company as not medically necessary, doctor non-participating in a plan or any other reason for nonpayment or reduced payment is the responsibility of the patient or responsible party.

Balances are due immediately. A monthly statement with any balances after insurance has been billed will be due within 30 days. Unpaid charges over 60 days will incur a monthly fee service of $25.00. If you have issues that prevent your paying the full balance due, please contact, Bonnie Bell, in our billing department. Accounts with no activity over 90 days may be forwarded for further collection action and therefore, the patient or guarantor will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency and attorney fees.

Verifying eligibility: You must have your insurance card in your possession at time of service. We honor many insurance programs, but it is your responsibility to verify that we accept your particular insurance plan prior to visit. Mission Family Practice does not assume responsibility for verification of benefits and/or coverage.

Minors: We cannot treat minors unaccompanied by an adult in a non-emergency situation without written authorization to do so by the parent or guardian.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

I understand that as a recipient of medical care, I the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of the service. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by my health care provider and the fees to compensate him for these services are matters which concern my healthcare provider and me. I understand that I have the primary duty and obligation to pay my healthcare provider for his services, notwithstanding any contract I may have with any third party payer(for example, insurance company, employer, etc).

I, the undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services rendered.

I hereby authorize my insurance company to pay or hereby assign directly to Mission Family Practice all benefits. I understand I am financially responsible for all charges incurred.

I am responsible for providing Mission Family Practice with complete and accurate billing information, including, but not limited to, a current insurance card and contact information, and pay applicable co-pays and outstanding balances as they are due.

I give my consent to Mission Family Practice to provide medical care and treatment to the below patient deemed necessary and proper in diagnosing or treating his/her physical condition.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED(patient or guarantor)_____ **Date**_____

For (Print Patient Name)_____

MISSION FAMILY PRACTICE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPPA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) regulations require us to provide to you, the patient or personal representative, a copy of our **Notice of Privacy Practices** and for you to sign as acknowledging receipt of this notice.

I hereby acknowledge that I have been given the opportunity to read and/or receive a copy of this medical practice's **Notice of Privacy Practices**. I further acknowledge that a copy of the current notice will be available in the reception area and that I will be offered a copy of any amended *Notice of Privacy Practices* at a subsequent appointment following the amendment.

_____Date:_____

Please Print Name

_____

Signature

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

1. Individual refused to sign.
2. Communications barriers prohibited obtaining the acknowledgement.
3. An emergency situation prevented us from obtaining acknowledgement.
4. Other (Please Specify):

Staff Signature:_____Date:_____