PATIENT REGISTRATION

PLEASE COMPLETE ALL INFORMATION (5 pages)

PATIENT DEMOGRAPHICS:

Marital Status: Please circle one: Married - Single - Divorced - Widowed

LEGAL NAME: ____________________________, _________________________________, __________________________
LAST NAME, FIRST NAME, MIDDLE NAME

DATE OF BIRTH: ___/___/_______ **Gender at birth:**__________ **Social Security#:**________________________
MM / DD/ YYYYY

Preferred Name/Nickname: _______________________________

Race: ___________________________________ **Ethnicity:** ____

MAILING ADDRESS: ___________________________________ ________________________ _________ ___________
STREET NAME CITY STATE ZIP CODE

PHONE: Cell_____________________ Home ________________ **EMAIL ADDRESS**:_______________________________

Please indicate, with a check mark, your permission for us to communicate with you by the following means:

Please check all that apply: Cell________________ Home _____ Email/Patient Portal__________________________

EMERGENCY CONTACT

Name:_________________________ **PHONE NUMBER**: ________________ **Relationship to patient:** ________________

PHARMACY:

LOCAL PHARMACY
NAME: ____
STREET & CITY:______________________________

MAIL ORDER PHARMACY
NAME: _____________________________________
STREET & CITY: ______________________________

INSURANCE:

Insurance Company: _____________________________ **Insured person**: _______________________________

Relationship to the Patient (if other than self): ___________________ **Insured's Date of Birth:** ____/____/_______

Insured's Address: ____

Insured Person's Employer: _____________________________ **Phone Number:** _________________________________

EMPLOYMENT:

EMPLOYER____ **EMPLOYER WORK #**______________________________

OCCUPATION/JOB TITLE:____

Is the reason for your visit work related? Circle one: Yes or No

Approving Supervisor: ___________________________________ **Phone Number**: _____________________________

FINANCIAL POLICIES:

At Valdosta Family Medicine Associates, P.C. we value you as a patient and value the services that we provide.
It is the policy to collect payment, upon check-in, of co-pays, deductibles, and deposits for services rendered. For this purpose, it is our policy to keep a credit card, bank card or bank account on file.

INSURANCE:

Our office files most health insurance policies, however, please inquire with the receptionist for specifics.
We DO NOT file care insurance or health insurance related to a motor vehicle accident. It is our policy that payment is made in full at the time services are rendered and the patient/guarantor will seek reimbursement from the responsible insurance party. We will provide a copy of the receipt upon request for your reimbursement.

UNPAID BALANCES:

The patient assumes responsibility for all unpaid balances, co-payments, and deductibles due, as well as any non-covered service by the insurance company, including costs of collections, including collection agencies. Unpaid balances may result in dismissal from the practice. Re-activation of care will be considered by administration only once balances are paid in full. There will be an additional $50 re-activation fee once balances are paid in full.

NO SHOW/SAME DAY CANCELLATION:

Patients who are unable to keep a scheduled appointment and do not notify us at least 24 hours in advance of the appointment will be charged a minimum fee of $25.00 up to $100.00, which we be collected prior to any future appointments or walk-in visits.

MINORS:

It is the policy of Valdosta Family Medicine Associates, P.C. that the person or parent accompanying a minor child be responsible for payment of co-insurance, co-pays, and deductibles at time of service. Divorce or custody agreements are between the two parties involved and not Valdosta Family Medicine Associates, P.C. We will provide a copy of the receipt for your reimbursement.
Children over the age of eighteen are considered adults and will be responsible for their own accounts.

ASSIGNMENT OF INSURANCE BENEFITS/ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby certify that the information given by me is accurate and complete. My signature below authorizes payment to be made to Valdosta Family Medicine, P. C. for services rendered, and approves release of any medical records or private health information (PHI) needed to process and pay the claim.
My signature also acknowledges that I have received a copy of the notice of privacy practices of Valdosta Family Medicine, P. C. on the date indicated below. I understand that if any changes are made to this notice of privacy practices, a revised copy of the notice will be posted in the offices of Valdosta Family Medicine, P. C.

My signature further states that I understand and will adhere to the policies of Valdosta Family Medicine Associates, P. C.

A COPY OF THIS AGREEEMENT WILL BE VALID AS THE ORIGINAL

_______________ ____

DATE **PATIENT OR GUARDIAN**

PATIENT'S MEDICAL HISTORY:

________________________________ ______________________ ____________ ____________________

Last Name **First Name** **Middle Initial** **DOB (mm/dd/yyyy)**

Date of last physical exam: ____________ **Doctor**:__________________ Referring Physician:________________________

Describe briefly your reason for establishing care:____

____

1. **Are you allergic to any drugs? Which one? What was the reaction?**

   ____

2. **Have you had any surgeries? If yes, what type? When?**

   ____

   ____

3. **Have you ever stayed overnight in the hospital? When? Reason?**

   ____

   ____

4. **Please list any previous medical problems (such as hypertension, heart attacks, strokes, cancer, diabetes)**

   ____

   ____

   ____

MEDICATIONS:

Please list all medications and dosages (including over the counter medications and supplements):

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

FAMILY HISTORY:

Please check if unknown/adopted________

FAMILY MEMBER	IF DECEASED, AGE AT DEATH	IF DECEASED, PLEASE LIST CAUSE
Father		
Mother		
Siblings: circle sex		
M F		
M F		
M F		
M F		
M F		
M F		
Daughters/Sons: circle sex		
M F		
M F		
M F		
M F		
M F		
M F		

Please indicate below any blood relative who has or had: (Circle and list relationship to you)

Alcoholism________________________

Aneurysm_________________________

Asthma___________________________

Bleeding Tendency_________________

Cancer____________________________

Diabetes__________________________

High Blood Pressure__________________________

Kidney Disease_______________________________

Macular Degeneration________________________

Mental Illness_______________________________

Seizures____________________________________

Stroke______________________________________

Heart Attack_______________________

Heart Failure_______________________

High Cholesterol_____________________

Substance Abuse Disorder____________________

Suicide____________________________________

Thyroid Disease_____________________________

PERSONAL HABITS:

1. **Do you exercise regularly? If so, how often and what types?**

   ____

2. **Do you use any of the following tobacco products?   If yes, how much per day?**

   Cigarettes ____

   Pipe____

   Smokeless Tobacco Products (dip, snuff, chewing tobacco)____

   Vape____

2. **Do you regularly drink alcohol?**

   How many times in the past year have you had 5 (4 for women) or more drinks in a day?________________

   Maximum amount per day? ____

   If less than daily, how often? ____

   Maximum amount per week? ____

   When was your last drink? ____

3. **Do you drink beer**?

   Bottles per day:____

4. **Have you ever felt you should cut down on your drinking**? ____

5. **Excluding any medications prescribed to you for a specific diagnosis, have you or are you currently using any of the following substances? Please check all that apply.**

   Amphetamines____

   Cocaine____

   Opiates (heroin, morphine, codeine)_____

   Opioids (fentanyl, oxycodone, hydrocodone, hydromorphone, oxymorphone, methadone, tramadol)______