DOCTOR'S CARE CENTER

REGISTRATION FORM

PATIENT INFORMATION
(PLEASE PRINT)

Date: _____

Is this a work related injury? Y N

Reason for Your Visit:

Is this a Motor Vehicle Accident? Y N

_____

Who referred you to our office?

☐ Friend / Relative ☐ Newspaper ☐ Internet ☐ Drove Past ☐ Insurance Co. ☐ Physician: _____

Last Name:	First:	Middle In:	Date of Birth:	Sex: M F
Address:			Social Security Number:	
City:	State:	Zip Code:	Name of PCP: ☐ I do not have PCP	
Home Phone: OK to leave message? ☐ Yes ☐ No	Cell Phone: OK to call: ☐ Yes ☐ No	Business Phone: OK to call: ☐ Yes ☐ No	Email: (Remains Private)	
Marital Status: (Circle One) Single Married Divorced Widowed Separated		Employment: (Circle One) Employed Retired Student Other: _____		
Current Medications:		Allergies:		

Employer Name:		
Street Address:		
City:	State:	Zip Code:

How will you be paying for today's visit?	☐ Debit Card ☐ Credit Card ☐ Cash ☐ Personal Check
	☐ Private Insurance: (Please complete the section below)

Primary Insurance Company:
Secondary Insurance Company:

Responsible Party or Subscriber: (If other than patient)		Relationship:
Street Address:		Phone:
City:	State:	Zip Code:
Date of Birth:	Social Security Number:	

Emergency Contact:	Phone:	Relationship:

DOCTOR'S CARE CENTER

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The colling is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor/physician assistant.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CHECKS (FOR ESTABLISHED PATIENTS ONLY), CASH, OR VISA/MASTERCARD & DEBIT CARDS.

REGARDING INSURANCE (*Please check with our billing department to see if we participate with your plan. Our front desk personnel are not responsible for such information.*)

Regarding Insurance Plans where we are a participating provider, all copays and deductibles are due prior to treatment. Please be aware that some services may be non-covered services and not considered necessary under the Medicare program and some insurance plans. In the event that the physician/physician assistant feels that these services are necessary, the fee(s) for the services will be placed under your responsibility. In the event that your insurance coverage changes to a plan where we are not a participating provider, please refer to the paragraph below.

If we are not a participating provider with your insurance plan, you will be responsible for the cost of each office visit. We will not bill your insurance for the bill. We will provide you with a receipt that you may submit to your insurance as proof of payment for any possible reimbursement the insurance plan may offer.

It is important for you to understand:
Your *health coverage* is an agreement between *you and your insurance company.*
Your *doctor's bill for the services provided* is an agreement between *you and your Doctor.*

WE <u>DO NOT ACCEPT</u> ANY FORM OF <u>MEDICAID</u> INSURANCE. YOU WILL BE BILLED FOR ANY BALANCE.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patiences and we charge what is usually and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS
Adult patients are responsible for full payment at time of service.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless a parent notified us in writing that we may treat the patient. The parent must also submit a Visa, Mastercard, Debit Card, Cash, or Check (FOR ESTABLISHED PATIENTS ONLY) prior to treatment.

INTEREST
We reserve the right to charge interest in the amount of 1.24%/month or 15% per year as provided by state law.
Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Thank you for understanding our Financial Policy. Please let us know about any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X _____ _____

SIGNATURE of Patient or Responsible Party (SEAL) DATE

DOCTOR'S CARE CENTER

HEALTH HISTORY

Name: _____ Today's Date: _____ /_____ /_____

Age: _____ Date of Birth: _____ /_____ /_____ Date of Last Physical Examination: _____

SYMPTOMS: PLEASE MARK BELOW IF YOU HAVE / HAD ANY OF THE FOLLOWING IN THE PAST YEAR

GENERAL

☐ Chills ☐ Depression
☐ Dizziness ☐ Fainting
☐ Fever ☐ Forgetfulness
☐ Headache ☐ Nervousness
☐ Numbness ☐ Sleep loss
☐ Sweats ☐ Weight loss

MUSCLE/JOINT/BONE

Pain, weakness, or numbness:
☐ Arms ☐ Back ☐ Feet
☐ Hands ☐ Hips ☐ Legs
☐ Neck ☐ Shoulders

GENITO-URINARY

☐ Blood in Urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination
☐ Leg pain - when walking

GASTROINTESTINAL

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

CARDIOVASCULAR

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

SKIN

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

EYE/EAR/NOSE/THROAT

☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Double vision
☐ Difficulty swallowing
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent Cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision:
☐ Flashes
☐ Halos

MEN only

☐ Breast lump ☐ Erection difficulties
☐ Lump in testicle ☐ Penis discharge
☐ Sore on penis
☐ Other: _____

WOMEN only

☐ Abnormal Pap Smear
☐ Bleeding between periods
☐ Breast lump ☐ Hot flashes
☐ Extreme menstrual pain
☐ Nipple discharge ☐ Painful intercourse
☐ Vaginal discharge
☐ Other: _____
Date of last period: _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children: _____

CONDITIONS: PLEASE MARK BELOW IF YOU HAVE / HAD ANY OF THE FOLLOWING IN THE PAST

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

MEDICATIONS: PLEASE LIST MEDICATIONS AND DOSES THAT YOU CURRENTLY TAKE

ALLERGIES: PLEASE LIST ANY MEDICATIONS OR SUBSTANCES YOU ARE ALLERGIC TO

HEALTH HABITS: CHECK & DESCRIBE

☐ Caffeine _____
☐ Tobacco _____
☐ Drugs _____
☐ Other _____

HOSPITAL ADMISSIONS OR SERIOUS ILLNESS/INJURY

YEAR	ILLNESS, INJURY OR OPERATION	YEAR	ILLNESS, INJURY OR OPERATION

FAMILY HISTORY: PLEASE LIST HEALTH INFORMATION ABOUT YOUR IMMEDIATE FAMILY & CHECK ALL THAT APPLY

RELATION	AGE	STATE OF HEALTH	YEAR OF DEATH	Diabetes	Cancer	Heart Disease	Hypertension	Stroke
Father:				☐	☐	☐	☐	☐
Mother:				☐	☐	☐	☐	☐
Siblings:				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐
Other:				☐	☐	☐	☐	☐

PATIENT SIGNATURE: _____ DATE: _____ /_____ /_____

DOCTOR'S CARE CENTER, P.A.

EFFECTIVE DATE: JANUARY 1, 2003

My signature below indicates that I have been given the opportunity to receive and read the:

NOTICE OF PRIVACY PRACTICES

As provided to be by Doctor's Care Center

X _____

Name of Patient (Please Print) (SEAL)

X _____

SIGNATURE of Patient (SEAL) (or Guardian/Parent if under 18 yrs of age)

Date Signed: _____/_____/_____

MEDICAL RELEASE OPTION:

I hereby give permission to disclose and/or release my medical information records to:

_____	_____	_____
Name	Relationship	Effective Date

OFFICIAL USE ONLY:

☐ Patient refused to sign

_____

Witness Signature