Select Family Practice
Registration Form

Today's date : _____
Patient Name : _____ DOB : _____
Age : _____ Social Security Number : _____
Gender : _____ Marital Status : _____ Race: _____ Ethnicity: _____
Preferred Language: _____ Street Address : _____
City:_____ State: _____ Zip Code: _____
Home Telephone : _____ Cell Phone: _____
Email address: _____
Pharmacy: _____
Can we leave voicemail with clinical information? Y/N
How did you hear about us? (circle one or more) Existing patient Friend/Family member Web search Drive by
In case of emergency, who would you like us to contact?
Name : _____ Relationship to you : _____ Contact number: _____
Do you give us permission to discuss your medical care with anyone other than yourself ? If so please leave name and relationship to you ?
1._____ 2. _____
Patient/ Guardian signature : _____ Date: _____

Name of Insurance Policy Holder: _____ DOB: _____ Relationship: _____

Patient Financial Responsibility Form

Select Family Practice will file insurance for all patients as a courtesy both in network and out of network. However, it is the patient's responsibility to pay all copays, deductibles and coinsurance at the time of service as well as any charges at the time of the visit.

Patient signature: _____ Date: _____

Privacy Practice Acknowledge

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Patient signature: _____ Date: _____

Consent

You expressly consent and agree that, in order to discuss or service your account(s) (the "Accounts ") or to collect amounts you may owe, Select Family Practice, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any email address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

Patient Signature: _____ Date: _____

Select Family Practice
Patient Intake Form

Name: _____ **DOB:** _____ **Age:** _____

Chief Complaint/ What are you here for today?

_____
_____
_____

How long has it been going on?

_____

Allergies to medication/reaction?

_____
_____
_____
_____

Medications and dosage?

_____
_____
_____
_____

Reason for taking the medications?

_____
_____
_____
_____

List of surgeries?

_____
_____
_____

Tobacco? Y/N **Cigarettes/Packs per day** _____ **Alcohol?** Y/N **Drinks/day** _____
Street drugs ? Y/N **What drugs?**_____

Family history of chronic illness (prior to 65 years of age)?
Father_____
Mother_____
Siblings_____
Aunt/Uncle_____
Grandparents_____

Preventative measures:
Tetanus/Tdap _____ Pneumonia _____
Flu _____ Pap Smear_____ Mammogram_____ Colonoscopy _____ PSA _____

To be filled out by provider:

Vital signs : Height _____ Weight _____ BP _____
Temp _____ Pulse _____ O2sat _____

Women only: Last menstrual cycle: _____ Pregnant _____
Breast feeding _____