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: _____

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._____ Relationship to you: _____
2._____ Relationship to you: _____

Parent/ Guardian signature:_____ Date: _____

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

<u>Patient Financial Responsibility Form</u>

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: _____

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Privacy Practice Acknowledgement

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 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 results in charges to you. You expressly consent and agrees that We may also contact you by sending text messages, emails, using any email address you provide 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 numbers, regardless of whether you incur charges as a result.

Patient Signature: _____ Date: _____

Select Family Practice
Patient Intake Form

Patient Name: _____ DOB: _____

Chief Complaint/ What are you here for today?

_____

_____

_____

How long has it been going on?

_____

Allergies to medication/ reactions?

_____

_____

_____

_____

Medication 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: _____ O_2Sat: _____

Women Only: Last Menstral Cycle: _____ Pregnant: _____
Breast Feeding: _____