Patient Registration Form

Eze Family Health Center - 11750 Business Park Drive, Ste 103 Waldorf, MD - Sepideh Dadras , MD / Chinyere Eze, PA-C

Patient Name:_____ **Social Security Number:** _____-_____-_____

Date of Birth: ____/_____/_____ **Sex:** M / F (Circle One) Married / Single / Divorced / Widow

Address:

_____

(Home Address) (City) (State) (Zip)

Cell Phone #: (____) _____-_____ **Home #:** (____) _____-_____ **Other:** (____) _____-_____

E-Mail Address: _____

Do you authorize having communications sent to you via your e-mail address? YES / NO
Do you authorize communications via text message to your cell phone? YES / NO

Employer Name: _____ Employer Phone Number: (____) _____-_____

How did you hear about our practice? _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-____-_____

Relationship to Patient: (please check): ( )Self, ( ) Spouse, or ( ) Parent Date of Birth: ___-___-___

Address: _____ Phone Number: _____

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency:

Name: _____Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____
Relationship:_____

Primary Insurance Information ____HMO _____PPO ***Please have insurance card with you***

Plan Name: _____ I.D. Number_____ Group #_____

Policy Holder: _____ Effective Date: _____Copay Amount $_____

Do you have Secondary Insurance ___Yes ___ No *(if Yes, please provide the receptionist this card)*

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Eze Family Health Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance. Additionally, I understand that there is a $25 No Show / Cancellation fee for non-emergent appointment cancellations not notified at least 24 hours in advance.

Signature:_____ Date: _____

Medical History Form

NAME_____ **DOB**___/___/___ **TODAY'S DATE**_____

MEDICAL HISTORY

What medical Conditions do you have? Select all that apply, or write in if not listed:

Diabetes___ High Blood Pressure___ Thyroid Disorder___ Heart Disease____ High Cholesterol____
Arthritis ____ Cancer____ Kidney Disease____ Glaucoma ___ Asthma____ Allergies____
Migraine Headache ____ Anemia____ Bronchitis/Emphysema____ Obesity____ Acid Reflux _____

Other: 1-_____ 2-_____ 3-_____

Women Only: Age of first menstrual cycle_____ Date of last period _____
Do you have a history of irregular menstrual cycles?_____ (Y / N)
Are you currently on birth control?_____ If yes, what type / name?_____
Number of pregnancies? _____ # of live births? _____ # of Miscarriages?_____
Have you had an abnormal Pap result? _____ If yes, when? (year)_____
How often do you self-breast exam? (circle one) Never Rarely Weekly Monthly

SURGICAL & HOSPITALIZATION HISTORY

List all of surgeries or hospitalizations (with cause) and the year:

_____ _____

_____ _____

SOCIAL

How much do you smoke?_____ How many years?_____
How much alcohol (including beer) do you drink in week?_____
Have you used or currently use recreational drugs? YES___ NO___ If yes how long_____
Please list people you currently live with:_____
Are you: ____Single ____Married ____Divorced ____Other?_____
Is your health (check one) ____Excellent ____Good ____Poor

Have you ever been a victim of domestic violence? Including: physical, psychological, emotional, economic, and sexual abuse? _____Do you have a gun in your house? ____YES ____NO
What is your occupation? Please include any unusual or potentially dangerous exposures you might have at work._____

Please list how often you exercise and what type: _____

SEXUAL HISTORY

Have you ever had a sexually transmitted disease? ____YES ____NO If yes, please list type(s)_____

FAMILY HISTORY

Please list if any family members have had the following illness. Please list their relation to you.

Family Member	Current Age	Living? (Y /N)	Medical Conditions	Cause of Death (if deceased)	Age at Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					

Continue on back of page if more

HEALTH MAINTENANCE

Please list the year of your last screening test below: (please indicate if there were any abnormal results)

PAP smear: _____ Mammogram: _____ Colonoscopy: _____ Eye Exam: _____

Cholesterol Test: _____ Prostate Exam: _____ Dental Exam: _____ Blood Work: _____

Immunizations/vaccine- Please list the year of your last:

Tetanus Shot: _____ Flu Shot: _____ Pnemovax (Pneumonia shot): _____ Hepatitis A_____
Hepatitis B: _____ Chicken Pox: _____ TB Skin Test:_____

Medications currently taking (with dosage):

Medication	Dosage	The time(s) of the day you take it

Vitamins or supplements currently taking:

_____ _____ _____

Allergic reactions to medicine or foods: Please list the TYPE OF REACTION.

Medication / Food Allergy Reaction

_____ _____

_____ _____

_____ _____

Are you allergic to LATEX? YES / NO

Please check any **CURRENT** symptoms with a **C** and any **PAST** symptoms with a **P**

GENERAL

_____Fever

_____Weight Loss

_____Weight Gain

EYES

____Vision Changes

____Double Vision

____Eye Pain/Irritation

MUSCULOSKELETAL

____Joint Pain

____Muscle weakness

____Back Pain

____Trouble Walking

____Cramping

SKIN

____Rash

MEN

____Difficulty urinating

____Trouble with erections

____ Change in urination

WOMEN

____PMS

____ Cramping

____ Abnormal vaginal bleeding

____Yellow Eyes (jaundice)

EARS, NOSE, THROAT

____Hearing Loss

____Sinus Pain

____Nose Bleeds

____Seasonal Allergies

____Lumps in mouth

____Jaw pain

____ New skin growths

____Change in Moles

____Warts

____Skin Cancer

____Itchy Skin

____Dry Skin

____Bleeding

____Oily Skin

____ Brittle nails

____Irregular menstrual cycle

____Lump in breast

____Abnormal discharge from nipples

____Uterine fibroids

____Excessive menstrual bleeding

-------- Hot flashes

_____ Mood changes

_____ "Heavy" sensation in abdomen

_____ Vaginal irritation

Ears, Nose, Throat

____Teeth or gum pain

____Ringing in Ears

____Soars in Mouth

____Difficulty swallowing

____Painful Swallowing

____Postnasal Drip

____Sneezing

CARDIOVASCULAR

____Chest Pain

____Palpitations

____Swelling of the Legs

____Irregular heartbeat

____Abnormal EKG

____High Cholesterol

____Shortness of Breath

RESPIRATORY

NEUROLOGIC

____Seizures

____Numbness

____Stroke

____Twitching

____Headaches/Migraines

____Dizziness

BEHAVIORAL

____Trouble Sleeping

____Trouble Concentrating

____Depression

____Feeling "blue" or "down"

____Marital problems

____Anxiety

____Mood swings

____Panic Attacks

GASTROINTESTINAL

ENDOCRINE

____Hair Loss

____Feeling or Cold

____Excessive Thirst

____Frequent Thirst

____Frequent Urination

____Excessive Hair Growth

HEMATOLOGIC

____Unusual Bleeding

____Unusual Bruising

____Anemia

____Enlarge Lymph Nodes

GENITOURINARY

____Kidney Stones

____Wheezing ____Stomach Pain ____Blood in Urine

____Coughing ____Ulcer ____Urinary Tract Infection

____Coughing up Blood ____Constipation

____Pneumonia ____Diarrhea

____Asthma ____Hemorrhoids

_____ Shortness of Breath ____Blood in Stool

OFFICE POLICIES

(UPDATED 6/16)

TO ENSURE THAT WE PROVIDE THE BEST HEALTHCARE SERVICES FOR YOU AS A VALUED PATIENT, WE ASK THAT YOU READ AND INITIAL BELOW TO ENSURE YOU UNDERSTAND OUR OFFICE POLICIES.

APPOINTMENTS & NO SHOW FEES

WE REQUIRE A **24 HOUR NOTICE** IF YOU ARE NOT ABLE TO MAKE YOUR SCHEDULED APPOINTMENT. IF WE DO NOT RECEIVE A PHONE CALL WITHIN 24 HOURS THERE WILL BE A NO SHOW FEE OF **$25.00**.

Initials _____

APPOINTMENTS AND OFFICE VISITS

YOU WILL BE SEEN BASED ON YOUR COMPLAINT AT THE TIME THE APPOINTMENT IS SCHEDULED. PRIMARY CARE AND WEIGHT LOSS VISITS ARE TWO SEPARATE TYPES OF VISITS. IF YOU CHOOSE TO COMBINE VISITS WE CHARGE YOU FOR PRIMARY CARE (CO-PAY) AND WEIGHT LOSS VISIT.

Initials _____

MEDICAL PAPERWORK / FORMS & LETTERS

IF YOU REQUIRE ANY MEDICAL PAPERWORK OR FORMS TO BE COMPLETED BY THE PRATICITIONER, YOU MAY BE REQUIRED TO COME IN FOR AN OFFICE VISIT (DEPENDING ON THE TYPE OF FORM). IF YOU ARE DROPPING OFF A FORM TO BE COMPLETED (WITHOUT AN APPOINTMENT), YOU ARE REQUIRED TO PAY A **$10.00** ADMINISTRATION FEE. ONCE YOUR REQUEST IS RECEIVED PLEASE ALLOW

UP TO **5 BUSINESS** DAYS FOR THE PAPERWORK OR LETTER TO BE COMPLETED. THIS INCULDES REQUESTS PAPER STATEMENTS AND RECIEPTS FOR PRIOR VISITS.

Initials _____

MEDICATION REFILL

PLEASE ALLOW AT LEAST **3 BUSINESS DAYS** FOR MEDICATION REFILLS TO BE PROCESSED AND REFILLED. PLEASE CALL THE PHARMACY FIRST TO ENSURE THAT THE PRESCRIPTION WAS RECEIVED.

Initials _____

By signing below, I understand and will abide by the office polices of Eze Family Health Center.

Signature _____ Date: _____

Financial & Health Services Policy

Welcome to *Eze Family Health Center*. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment**. You will be responsible for your payment portion at the time of service**. F**ailure to provide current, accurate billing information will result in all charges for service becoming the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and responsibilities**. All copays, co-insurance and deductibles are due and payable at the time services are rendered.** If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.
In consideration of the services performed by EZE Family Health Center you agree to abide by the terms of this Financial Statement.

_____

Patient Initials

PATIENT AUTHORIZATION

I certify that I, and /or my dependent(s), have insurance coverage with **(insurance company)**

_____

and assign directly to Eze Family Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I request payment form all insurance's including Medicare be made directly to EZE Family Medical Center. I authorize the use of my signature on all insurance submissions. EZE Family Health Center may use my health care information and may disclose such information to the above name insurance carrier for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PRESCRIPTION MEDICATION POLICY

Eze Family Health Center is committed to providing quality health care services for our valued patients. In keeping with this commitment, we discourage any potential issues of fraudulent use or abuse of controlled medications. It is our policy here at Eze Family Health Center, that **no Schedule I or Schedule II pain medications will be prescribed** from our facility. If an intense course of pain management is warranted, we will assist patients with transitioning their healthcare to a Pain Management specialist.

Eze Family Health Center reserves the right to refer patients to other medical specialists if patient's needs are beyond the scope of practice of our medical facility.

I certify that the above information I have provided on this form is correct. By signing, I understand and will follow the policy.

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

Protected Health Information (PHI) / HIPAA

Patient Keep Copy

Patient Name (Print) _____ Date_____

Due to recent implemented Federal Regulations the following public notice by EZE Family Health Center is effective as of November 1, 2011.

By Law EZE Family Health Center is required to:

Maintain the privacy of your health information.

- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.
- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.
- We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.

2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.

3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voic3e mail or answering service regarding appointments and billing questions.

There will be no information given over the phone or fax in reference to lab results. Each patient is given this information during their examination, and they are to schedule a follow-up visit to obtain lab results.

Patient with a normal pap will be notified by contacting the lab line directly. If your result is abnormal, you will be asked to contact your physician office directly.

All requests for medical records should be written and contain:

- **Social Security Number**
- **Date of Birth**
- **Insurance Carrier**
- **Mailing Address**
- **Written Signature**

In addition an advanced fee will be accessed for copy and mailing of all medical records information.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

There will be a fee of $15 dollars to complete medical forms containing 1-2 pages, and $25 for forms that contain 3 or more. Medical forms such as: school physicals, work physicals, and any other form(s) which may require the use of your medical record to complete your request.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions**: You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to suspect and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances; however, you may request a review of our denial.

4. **Amendment:** You may ask us to amend health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. You request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any question regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Privacy Officer
EZE Family Health Center
11750 Business Park Drive
Suite 103
Waldorf, MD 20601
Phone (240-419-3865

Eze Family Health Center

Complete then return to Receptionist*

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Eze Family Health Center, and understand that if I have questions regarding this Notice I may contact the Privacy Officer at 11750 Business Park Lane Suite 103 Waldorf, MD 20601 (240) 419-3865.

Indicated below are names of any Person(s) to who I would like Eze Family Health Center to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate “All” if appropriate).

Name	Relation (Spouse, Child, Friend, etc.	Allowed Disclosure
1.		

2.		
3.		

_____ _____

Patient Signature Date

_____ _____

Signature Legal Guardian Date

Relationship to Patient_____

FOR OFFICE USE ONLY
Date Received: _____
Received By: _____