Date: _____

ADULT PATIENT REGISTRATION FORM

✓*By completing this questionnaire you provide us with important, basic information for our records.*

Patient's Name:_____Patient's Date of Birth:___/____/____

Patient's Home Address: _____

_____

Primary Contact Phone: (_____)_____ ☐home ☐work ☐cell
(Appointment reminders are received at this number)

Secondary Contact Phone: ( )_____ ☐home ☐work ☐cell

Email address:_____ **How did you hear about us**: _____

****

INSURANCE INFORMATION

Primary Insurance

Insurance Subscriber Name: _____DOB ___/____/___ (Name of person who carries the insurance)

Health Plan:_____ Group No: _____ ID No: _____

Secondary Insurance

Insurance Subscriber Name: _____DOB ___/____/___ (Name of person who carries the insurance)

Health Plan:_____ Group No: _____ ID No: _____

****

Financial Responsibility for Services Rendered by HT Family Physicians

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been processed and paid. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to myself or a member of my family.

I acknowledge that medical billing statements for services rendered by HT Family Physicians will be sent to the person who carries the insurance for the patient/family member.

Signature: _____ **Date**: _____

RELEASE OF MEDICAL INFORMATION

If you would like to authorize our office to release your personal medical information to another individual i.e. husband, wife, parent, adult child, sibling, please sign the authorization below.

I hereby authorize HT Family Physicians to release my medical information to the following individual:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I may revoke this authorization any time by notifying HT Family Physicians.

Signature: _____ Today's Date: _____

****

I have been given a copy of HT Family Physicians' Notice of Privacy Practices.

Signature: _____ Date: _____

****

LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold your appointment for a 10 minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically canceled thereafter. If you arrive after your appointment has been cancelled, you will be asked to reschedule the appointment.

MISSED APPOINTMENT OR "NO-SHOW" POLICY

It is your responsibility to remember your scheduled appointment. After three (3) missed appointments, we may choose to discontinue your care.

_____ _____

Your Signature Acknowledges Receipt Date

****

HEALTH MAINTENANCE INFORMATION

Last Physical Exam: _____	**Last Mammogram: _____**	**Last Blood Tests: _____**
Last Pap Smear: _____	**Last Eye Exam: _____**	**Last Colonoscopy _____**

Last Name	First Name	Date of Birth
		/ /

PAST MEDICAL HISTORY

Place a checkmark (✓) next to the conditions you have now or have had in the past.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Disorder
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hay Fever /
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraine
- ☐ Prostate Problems
- ☐ Seizures
- ☐ Stroke
- ☐ Other Illness:

Women Only

- ☐ **Abnormal Pap**
- ☐ **Vaginal discomfort**
- ☐ **Urinary problems**
- ☐ **Discomfort during sexual relations**
- ☐ **Are you menopausal or peri-menopausal?**
- ☐ **Vulvar or vaginal dryness**
- ☐ **Frequent urinary infections**

Age started menses:_____
Days bleeding:_____
Pregnancies:_____
Live births:_____
Miscarriages:_____# Abortions:_____
Contraceptive method:

PAST HOSPITALIZATIONS / SURGERIES

Year	*Hospitalization for…*	*Illness / Injuries*	*Surgeries*

CURRENT ALLERGIES, SENSITIVITIES, INTOLERANCES

List anything you are allergic/sensitive to (medication, foods, chemicals, etc.) and how each affects you.

Allergic to…	***Effect***

CURRENT MEDICATIONS

List all medications you are now taking, including those you buy without a prescription. List name, dose, and how often per day.

FAMILY HISTORY

Have any blood relatives had any of the following? If so, indicate relationship to you.

ILLNESS	*FAMILY MEMBER*	*ILLNESS*	*FAMILY MEMBER*
Alcoholism		High Blood Pressure	
Blood Disease		Mental Problems	
Cancer		Migraine	
Diabetes		Stroke	
Heart Disease		Suicide	
Other:			