Arbor Green Family Medicine Clinic

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth Date	Social Security Number	Age	Sex ❑ M ❑ F

Street Address	Apt#	Home Phone #	Cell Phone #

City State ZIP Code

Occupation	Employer	Employer Phone #

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone #
Is this person a patient here?	❑ Yes ❑ No		Cell Phone #

Occupation	Employer	Employer Address	Employer Phone #

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Name of Insurance Co	ID#	Group #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone #	Work Phone #

The above information is true to the best of my knowledge. I authorize **Arbor Green Family Medicine Clinic** to provide myself or my child with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I authorize **Arbor Green Family Medicine Clinic** or the insurance company to release any information required to process my claims. I understand that Arbor **Green Family Medicine Clinic** has the right to refuse or accept assignments of such benefits. If these benefits are not assigned, **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT HISTORY FORM

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENNCE DATE TODAY:_____

AND WILL NOT RELEASE WITHOUTH SIGNED. IT MAY BE SENT TO CONSULTANTS IF REFERRED.

NAME: _____ **BIRTH DATE:** _____ **AGE:** _____

LAST FIRST MIDDLE

MARITAL STATUS: ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) SEPERATED ( ) DIVORCED

OCCUPATION:

REASON FOR VISIT TODAY:

LAST MEDICAL EXAM:

LAST DOCTOR:

LAST CHEST X-RAY (DATE AND LOCATION)

ALLERGIES (DRUGS, X-RAY,DYE,TAPE,LATEX)/& TYPE OF REACTION:

PHARMACY NAME: _____ **PHARMACY NUMBER:** _____

MEDICATIONS: (LIST ALL INCLUDING ONES NOT PRESCRIBED. (SUCH AS ALTERNATIVE AGENTS OR HERBAL AGENTS)

DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e. ADVIL	200 MG	3 TIMES PER DAY	6 MONTHS

PLEASE KNOW WHAT DRUGS AND DOSES YOU TAKE; IF YOU NEED REFILL LET THE NURSE KNOW WHEN SHE PLACES YOU IN THE EXAM ROOM

CHILDHOOD ILLNESSES: ( ) CHICKEN POX ( ) MEASLES/RUBEOLA ( ) MUMPS ( ) RUBELLA ( ) SCARLET FEVER

PREVIOUS MEDICAL ILLNESSES/HOSPITALIZATION (OTHER THAN UNDER SURGERY)

SURGERY: (IF YES, PLACE AN (X) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( ) APPENDECTOMY _____ ( ) C- SECTION _____ ( ) HERNIA REPAIR ( ) OVARY R / L _____

( ) BREAST BIOPSY _____ ( ) GALLBLADDER _____ ( ) HYSTORECTOMY ( ) TONSILLECTOMY _____

( ) CAROTID ARTERY _____ ( ) HEART ANGIOPLASTY _____ ( ) MASTECTOMY

( ) CATARACTS _____ ( ) HEART BYPASS _____ ( ) PROSTATE REMOVAL

OTHER SURGERY NOT LISTED:

OB/GYN HISTORY: **PREGNANCIES:** **DELIVERIES:** **LAST MENSTRUAL CYCLE:**

** CHECK _____ IF YES OR WRITE NO, IN FRONT OF ITEMS THAT FOLLOW BELOW

_____ DO YO USE TOBACCO CURRENTLY? _____ # OF PACKS PER DAY? _____ # OF YEARS

ARE YOU INTERESTED IS STOPPING? (Y_____) (N_____)

_____ TOBACCO USE IN PAST? _____ WHEN DID YOU STOP?

_____ ALCOHOL USE? BEER_____ WINE_____ MIXED LIQUOR OZ (OR GLASSES OR CANS PER WEEK) _____

_____ CAFFEINE USE? _____ CUPS PER DAY? _____ SODAS PER DAY?

_____ EXERCISE REGULARLY? _____ TYPE OF EXERCISE? _____ TIMES PER WEEK?

*** GOAL OF 30 MINUTES OF WALKING-TYPE EXERCISE 5 DAYS PER WEEK RECCOMMENDED***

Arbor Green
Family Medicine Clinic
www.arborgreenclinic.com

HANIA ALAIDROOS, M.D.

AUTHORIZATION for VERBAL COMMUNICATION

with ANOTHER PERSON on MY BEHALF

I, _____, authorize my healthcare provider, Hania Alaidroos M.D. / Risha Kopel M.D., to use and/or disclose my health and medical information, including but not limited to: medications, labs, x – rays, radiology reports, referrals, claims, benefits, eligibility, appeals, premiums, and other healthcare provider records to:

_____ _____

Print Personal Represenative(s) Name Phone Number of Represenative(s)

_____

Relationship to Patient

I further understand that my health and medical information may include information about:

- Drug and/or alcohol abuse history, diagnosis and treatment.
- Psychiatric history, diagnosis and treatment.
- AIDS/HIV, sexually transmitted diseases, hepatitis and/or other infectious disease history, diagnosis and treatment.

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

Finally, I understand that I may revoke or change this authorization in writing at any time, provided that I do so in writing or complete a new form with the changed information. I further understand that this authorization will stay effective until I make a change (complete a new form) or revoke (in writing) this authorization.

_____ _____

Signature of Member Date

HANIA ALAIDROOS, M.D. ARBOR GREEN FAMILY MEDICINE CLINIC
Patient Consent and Acknowledgement of Receipt of Privacy

I understand that as a part of the provision of healthcare services Hania Alaidroos, M.D. creates and maintains health records and other information describing among other things, my health history, symptoms, examinations, test results, diagnoses and treatments and any plan future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that organization reserves rights to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations (quality assessment and improvement activities, and auditing functions, etc.) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing except disclosures that I have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, were written or in electronic form are confidential and cannot be disclosed for reason outside of treatment, payment or healthcare operations without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this consent is as this original
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or Healthcare Operations, be restricted. I also understand that the Practice and i must agree to any restriction in writing that i request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient's Name Printed _____ Date: _____

Patient's Signature (or Guardian, if A Minor) _____ Social Security Number (For id Purposes) _____

Witness (optional) _____ Date: _____

HANIA ALAIDROOS, M.D. ARBOR GREEN FAMILY MEDICINE CLINIC
PRE-TREATMENT NOTIFICATION

Some health plans require that we inform you in advance that they may deny payment for services not covered and for services not deemed by the health plan to be reasonable and customary or medically necessary. Hania Alaidroos, M.D. renders only services that, in her professional judgment, are needed to provide quality medical care for you. In order for us to collect from you for our services when payment is denied by your health plan, your health requires that you sign the following agreement.

Agreement: I have been notified by the physician that payment may be denied for "services not covered" or for "deemed by health plan to be reasonable and customary or medically necessary" or that have been specifically requested by me, the patient. If payment is denies, I agree to be personal and fully responsible for payment.

Signature: _____ **Date** _____

YOUR HEALTH PLAN COVERAGE

Hania Alaidroos, M.D. is committed to providing you with the best possible care and helping you need to receive maximum allowed benefits under your health plan. In order to achieve these goals we need your assistance.

REGARDING OFFICE VISITS, LAB WORK & X-RAYS

1. Co-Payments are due at time of each visit
2. A valid, current card must be presented at each office visit.
3. If the service is not a covered benefit or if your health plan tells us you are not covered, payment in full for all services are due when rendered. If your insurance subsequently makes payment any overpayment will be refunded to you.

REGARDING YOUR HEALTH PLAN

1. Your insurance is a contract between you, your employer and the insurance company. We are not a part of the contract. While we may have an agreement with many of the health plans to provide services, any questions regarding your coverage must be resolves with the insurance company.
2. Not all services are a covered benefit with all contracts. Some health plans select certain services which they will not cover. By signing below, I acknowledge that I have read and fully understand all of the above.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____