BALD EAGLE
FAMILY MEDICINE

Patient Registration Form

Patient's Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ Sex: M / F SSN: _____

Patient's Phone Number: _____

Alternate Phone Number: _____ (Home / Cell / Work)

Address: _____ Apt/Unit. # _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Emergency Contact: _____

Relationship to Patient: _____

Address: _____

Phone number: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian
[ ] Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please specify: _____

Cancellation Policy

Bald Eagle Family Medicine reserves the right to charge a fee for any scheduled visits that are:

1. **Cancelled** with less than 24 hours of proper notice.
2. Are **missed** without calling to cancel (no show)

Cancellation Fee: New Patient $50.00; Established Patient: $35.00

Patient / Parent or Guardian Signature: _____
Date: _____

*A COPY OF YOUR INSURANCE CARD/S IS REQUIRED

INSURANCE INFORMATION

Primary : _____
Policy ID# _____
Group # _____

Patient Is Subscriber/Policy Holder: Y / N

Secondary: _____
Policy ID # _____

Patient is Subscriber/Policy Holder: Y / N

INSURED INFORMATION (IF OTHER THAN PATIENT) -

Subscriber/ Policy Holder: _____

Date of Birth: _____

Relationship to Patient: _____

Address: _____

Social Security Number: _____

Employer if Commercial Policy: _____

HR Phone Number: _____

Medical Information/ Health History

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Name of Medication	Dosage	Route	How often taken/Directions

Any **Allergies** to Medications (please list type of reaction and severity):

_____

_____

Preferred **Pharmacy**: _____

Name of previous primary care physician: _____

Other physicians that provide care for you: Please list name, location and specialty.

_____

_____

Date of Last Physical Exam: _____ Date of Last Blood Work: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

For Females: Date of Last Menstrual Period: _____ Last Pap Smear: _____

Have you ever had an abnormal PAP? Y / N (If yes, when was it?) _____
Date of Last: Mammogram: _____ DEXA: _____

Number of full term Pregnancies: _____ Miscarriages: _____ Terminations: _____
Premature births: _____ Living Children: _____

Method/s of Contraception: _____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/Depression	Heart Attack	Thyroid Disorder
Alcoholism	Kidney Disease	Sexually Transmitted Disease
Blood Clots	Liver Disease	Other:
Cancer, Type/s/Relative	Neurological Disease	_____
	Osteopenia/Osteoporosis	_____

Please list any **SURGERIES** you have had. Please include the month/year:

_____

_____

Social History

Tobacco Use: Do you smoke or vape? Y / N
How much/often? _____ Cigarettes / Packs / Vape pens/cartridges - Every: Day /Wk/ Mo
No. of years using tobacco products: _____ Do you chew or use smokeless tobacco ? Y / N
Have you thought about quitting? Y / N
Have you quit before? Y / N For how long? _____ Weeks / Months / Years

Alcohol Use: Do you drink alcohol? Y / N If so, what kind? _____
How often? _____ (drinks / beers / glasses of wine) every (day / week / month)

Drug Use: Any history of illegal drug use? Y / N If so, what type/s? _____
When was the last time you used? _____

Physical Activity: What is your level of activity? Low / Moderate / High
Do you exercise? Y / N
What activities do you do, and how often? _____
Are you on any special diet? Y / N If so, what kind? _____
Do you consume any caffeinated products? Y / N How much? _____ per Day / Week / Mo
Have you recently noticed an increase in sadness or gloominess? _____
Have you lost interest in enjoyable activities? Y / N
Do you have a living will? Y / N
If yes, please provide us a copy.

Reason for Visit

Please give us a brief description of what brings you in today:

_____
_____
_____
_____
_____
_____.

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Bald Eagle Family Medicine (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Bald Eagle Family Medicine (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Bald Eagle Family Medicine for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. **Residents, Interns or Medical Students-** I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Bald Eagle Family Medicine education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Bald Eagle Family Medicine. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Bald Eagle Family Medicine unless specifically rescinded in writing by me.*

Patient or Guardian Signature: _____

Relationship to Patient: _____

Date: _____

Notice of Privacy Practices

I certify that I have been made aware of Bald Eagle Family Medicine **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Bald Eagle Family Medicine care operations. The Notice also describes my rights and Bald Eagle Family Medicine duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Bald Eagle web site at www.baldeaglefamilymedicine.com I may request that a copy be mailed to me by calling **682-205-1079**

Bald Eagle Family Medicine reserves the right to change the privacy practices that are described in the

I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Bald Eagle Family Medicine web-site listed above to view the most current version.

_____

SIGNATURE OF PATIENT, AUTHORIZED REPRESENTATIVE OR GUARDIAN

_____

PRINTED NAME OF PATIENT, REPRESENTATIVE OR GUARDIAN

_____

DATE

_____

DESCRIPTION OF GUARDIAN OR REPRESENTATIVE'S AUTHORITY