



## Patient Registration Form

Patient's Name (Last, First, MI): \_\_\_\_\_

Patient's Home Phone Number: \_\_\_\_\_

Alternate Phone Number ( cell or  work): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Social Security Number: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Patient's Employer: \_\_\_\_\_

Employment Status:  Full time  Part time  Unemployed

Retired  Student  Other: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Patient is Subscriber/Policy Holder: Y N

Patient is Subscriber/Policy Holder: Y N

**INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card**

Subscriber/ Policy Holder: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address:

\_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

His or Her Employer: \_\_\_\_\_ Work Phone Number:

\_\_\_\_\_

### **RELEASE OF INFORMATION**

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient. Bald Eagle Fam

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

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

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

Patient / Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## HEALTH HISTORY

**Personal Information** Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Occupation \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Partner/Spouse: \_\_\_\_\_

**Race:**  Asian  Black or African American  Native American  White / Caucasian  
 Other: \_\_\_\_\_

**Ethnicity:** Do you identify with an Ethnic origin? If yes, please note: \_\_\_\_\_

Number of children: \_\_\_\_\_ Children's Names/Ages: \_\_\_\_\_

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor: \_\_\_\_\_

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### Medical Information

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

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): \_\_\_\_\_

Preferred **Pharmacy:** \_\_\_\_\_

Date of Last Complete Physical Exam: \_\_\_\_\_ Date of Last Blood Work: \_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

**For Females:** Date of Last Menstrual Period: \_\_\_\_\_ Date of Last Pap Smear: \_\_\_\_\_

History of Abnormal Pap (list date/s)? \_\_\_\_\_ Date of Last: Mammogram: \_\_\_\_\_ DEXA: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Terminations: \_\_\_\_\_ 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:

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

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

\_\_\_\_\_

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**Social Information**

**Tobacco Use:** Do you smoke? \_\_\_\_\_ If so, how many cigarettes/cigars per day: \_\_\_\_\_ No. of years smoking: \_\_\_\_\_ Do you chew tobacco? \_\_\_\_\_ Have you thought about quitting? \_\_\_\_\_ Have you quit before? \_\_\_\_\_ How long? \_\_\_\_\_

**Alcohol Use:** Do you drink alcohol? \_\_\_\_\_ If so, what type? \_\_\_\_\_ How many in 1 week? \_\_\_\_\_

**Drug Use:** Any history of illegal drug use? \_\_\_\_\_ If so, what type/s? \_\_\_\_\_ When?  
\_\_\_\_\_

Do you **exercise**? \_\_\_\_\_ What activities do you do, and how often in 1 week? \_\_\_\_\_

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Are you on any special **diet**? \_\_\_\_\_ If so, what?  
\_\_\_\_\_

Do you consume any **caffeinated** products? \_\_\_\_\_ If so, what and how much per day?  
\_\_\_\_\_

**Have you recently noticed an increase in sadness or gloominess?** \_\_\_\_\_

**Have you lost interest in enjoyable activities?** \_\_\_\_\_

Do you have a living will? \_\_\_\_\_ If yes, please provide us a copy.

## **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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

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](http://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

**Notice of Privacy Practices.** 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 OR PERSONAL REPRESENTATIVE

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NAME OF PATIENT OR PERSONAL REPRESENTATIVE

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DATE

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DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY