Print

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip:_____

Email:_____Occupation:_____

Date of Birth: _____ **Sex:** ☐M ☐F **Marital Status**: ☐Married ☐Single ☐Divorced **Preferred Language**: _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Primary Care Physician's Name (if applicable): _____ Preferred Pharmacy: _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to patient: ☐Self (Skip to next section) ☐Parent ☐Spouse ☐Others (Skip to next section)

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ **Sex:** ☐M ☐F

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____ Policy effective date: _____

Address: _____ City: _____ State: _____ Zip:_____

Policy Number: _____ Group Number:_____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____ _____

Address: _____ City: _____ State: _____ Zip:_____

Policy Number: _____ Group Number:_____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Signature: _____ **Date**: _____

EMERGENCY CONTACTS

I authorize Medical Associates of Fremont, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Medical Associates of Fremont to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.

_____
Patient initials

CANCELLATION POLICY

Medical Associates of Fremont reserves 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: $25

Parent/Parent or Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I received a copy of the Medical Associates of Fremont "Notice of Privacy Practices" today and agree with these privacy policies.

_____
Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Medical Associates of Fremont, to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to BMG from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Medical Associates of Fremont.

_____
Patient initials

_____ _____

Date **Signature of Patient or Guardian if patient is Minor**

Patient Name: _____ DOB: _____

PATIENT HISTORY FORM

Place a check **√** beside any medical problem (s) you have had in the past or may currently have and include year if known.
Place a check **√** beside any medical problem (s) any family member has had in the past or may currently have and list relationship using key:

M – Mother; F – Father; GM – Grandmother; GF – Grandfather

PATIENT AND FAMILY

	Patient	Year	Family		Patient	Year	Family
Anemia				Immune Deficiency			
Arthritis				Liver Disease			
Heart Arrhythmia/Palpitations				Kidney Disease			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer: Type:				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder disease				Reflux			
Gastric Ulcers				Skin ulcer/breakdown			
Glaucoma / Loss of Vision				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis (TB)			
Hepatitis B / Hepatitis C				Urinary Infections			
High Blood Pressure				Valve Disorders (Heart)			
HIV/AIDS				Wound Healing Problems			

List any medical problem(s) not listed above:

Are you experiencing any of the above problem(s) today? ☐Yes ☐No If Yes, when did symptoms begin? _____
If you checked yes, please explain: _____
_____

Have you had a pneumonia shot? ☐Yes ☐No If yes, when _____

When was your last flu shot? _____

Please check √ if you have any allergies: ☐Yes ☐No If yes, please list: _____
_____
Please check √ if you have any medication allergies: ☐Yes ☐No If yes, please list: _____
_____

Please list current medication(s) below:

1. _____ Dosage _____
2. _____ Dosage _____
3. _____ Dosage _____
4. _____ Dosage _____
5. _____ Dosage _____

Please list any surgeries and/or hospitalizations you have had below and, if possible, physician(s) and date (s). (Continue on back if needed)

1. _____Physician: _____ Date: _____
2. _____Physician: _____ Date: _____

SOCIAL HISTORY

Alcohol? ☐Yes ☐No If yes, drinks per week: _____ Smoking/Tobacco? ☐Yes ☐No If yes, Packs/day: _____ Years: _____

History of Illicit Drug Abuse? ☐Yes ☐No If yes, kind(s) of drug: _____ Frequency: _____

Smokeless Tobacco? ☐Yes ☐No Frequency: _____ Daily caffeine intake (Coffee, tea, sodas)? _____

Patient Signature: _____ Date: _____

Print