WEST SHORE FAMILY PRACTICE, P.C

Patient Registration Form

Patient information (please print):

Name: _____ (Last) _____ (First) _____ (Middle Initial)

Address: _____ S.S.#: _____

_____ Home phone: _____

_____ Work phone: _____

Birthdate: ____/____/____ Gender: Male_____ Female_____

Marital Status: (circle) Single Married Widowed Divorced Separated

Emergency Contact Name: _____ Relationship: _____ Phone#_____

Other person(s) living in your household and relationship to you (Adults & Children):

_____ _____

_____ _____

Responsible Party Information: (for minors/ less than 18 years old])

Please list both parents names and information (Please ask for an additional form if needed)

Name: _____ Relationship: _____

Address: _____ S.S.#: _____

_____ Home phone: _____

Work phone: _____

Employer Name: _____

Employer Address: _____

Employment Information:

Employment Status: (Circle) Full-time Part-time Retired Military Self-employed Not employed Student

Company Name: _____ Job Position: _____

Address: _____ Phone #_____

City/State_____ Contact Person_____

Insurance Information: *Please provide our receptionist with your insurance card for us to copy.*

Primary Insurance: _____ Subscriber: _____

Address: _____ Relationship: _____

_____ Group #: _____

Phone: _____ ID#: _____

Second Insurance: _____ Subscriber: _____

Address: _____ Relationship: _____

_____ Group #: _____

Phone: _____ ID#: _____

Name of previous family doctor: _____

Address: _____

Other Providers (Specialists, Chiropractors, Physical Therapists, Physician Assistants) you see:

Names: _____ For What Problem(s): _____

_____ _____

WOULD YOU PLEASE SHARE WITH US HOW YOU HEARD ABOUT WEST SHORE FAMILY PRACTICE? _____

_____ OVER→

West Shore Family Practice, P.C.

PATIENT NAME (PRINT):_____

BENEFICIARY NAME (PRINT):_____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL RECORD(S)

ALL Patients' / Authorized Person's Signature Required:

Insurance Authorization and Assignment:

"I authorize that payment be made directly to the doctor for all medical, surgical, and hospital benefits entitled to me. I understand that I am financially responsible to the doctor for charges not covered by this assignment and/or remaining (outstanding) balances."

(Guarantor Signature) _____ (Date) _____

ALL Patients' / Authorized Person's Signature Required:

"I agree that if I do not pay my full account balance within 30 days, West Shore Family Practice P.C. may refer this account to its collection agency, and/or attorneys, for collection efforts. I will also be responsible for, and agree to reimburse, West Shore Family Practice P.C. for any and all reasonable collections fees (currently 30% of unpaid balance due), including legal fees, filing fees, interest, service cost, and disbursement incurred as a result of the collection efforts."

(Guarantor Signature) _____ (Date) _____

Medicare Patient or Authorized Person's Signature:

"I request that payment of authorized Medicare benefits be made to either me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable for related service."

(Guarantor Signature) _____ (Date) _____

Medicare/Medigap Patient (Secondary Insurance) or Authorized Person's Signature:

"I request that payment of authorized benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to (Name of Medigap Insurer) _____ any information needed to determine these benefits payable for related services."

(Guarantor Signature) _____ (Date) _____

WEST SHORE FAMILY PRACTICE, P.C.

NAME_____ AGE_____ DATE_____

; FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE TIME TO
'LLY AND COMPLETELY FILL OUT THIS IMPORTANT INFORMATION. WE ARE COUNTING ON
YOU. IF NEEDED, PLEASE ASK FOR ADDITIONAL PAPER.

Medications currently taking, (including aspirin, vitamins, etc.) strength and number per day: _____

_____

_____

Allergies to medications and other drug reactions: _____

_____

(Please list name of medicine and the reaction you had)

Change in Wt. (___No) (___Yes) (#lbs____, time period_____) Increase or Decrease (Please Circle)

OPERATIONS/SURGERY	DATE	SURGEON (IF KNOWN)

Other stays in hospital (When and Why): _____

_____

Work or other exposure to chemicals, radiation, asbestos dust, coal dust, blood products, transfusions, metals, idemic diseases: _____

_____

. Injuries - and lasting effects: _____

_____

. WOMEN ONLY:

Pregnancies (#_____), Term babies (#____), Preterm babies (#____), Miscarriages (#____), Abortions (#____),
No. of Children Living (#____)

Complications:_____

Breast Problems:_____

Menstrual Cycle: ___Regular ___Irregular Every _____ days.

Period length:____Days; Flow:____light ____mod. ____heavy

Painful periods:____Yes ____No (____Severe)

Menopause (____Yes) (____No) ____Severe Symptoms_____

HISTORY SHEET(Side 1)

PLEASE TURN OVER TO COMPLETE SIDE TWO.

OVER→

I. PAST MEDICAL AND FAMILY HISTORY:

(Please mark an "X" in the spaces below which apply to you or your family history)

	Me	Father	Mother	Father's father	Father's mother	Mother's father	Mother's mother	Sisters/ brothers
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Cancer								
Peptic Ulcer Disease								
Colitis/Crohn's								
Asthma/Lung Disease								
Thyroid Disease								
Bleeding Disorders								
Venereal Disease								
Arthritis								
Kidney Disease								
Nervous/Emotional Disorder								
Anemia								
Glaucoma								
Tuberculosis/TB								
Seizures								

J. Tobacco/Smoking: What type?_____ Howlong?_____
How much?_____ Stopped?_____

Alcohol: What type?_____ Howlong?_____
How much?_____ Stopped?_____

Recreational Drugs?_____ Coffee/Tea?_____ Other _____

K. Where lived/traveled outside Northeastern U.S.:_____

_____

L. Home water supply: _____well _____public Fluoride tested?_____

M. Other Physicians, Specialists, Chiropractors, Physical Therapists, etc. seen:_____

_____

_____

N. Circle if you have ever had: Chicken pox Measles Mumps

O. IMMUNIZATIONS:

	DATE
Tetanus (+/- diphtheria)	_____
MMR (measles, mumps, rubella)	_____
Pneumonia Vaccine	_____
Chicken Pox Vaccine	_____
Flu Vaccine	_____

The above is true and correct to the best of my belief.

Signature of patient or authorized representative:_____

Relationship of authorized representative to patient:_____