COPPELL ASSOCIATES IN FAMILY MEDICINE P. A.

REGISTRATION FORM

Patient Information

Patient Name: _____ DOB: _____

Patient Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Email: _____ Work Phone: _____

Social Security: _____

Sex: (Circle) Male OR Female Preferred Pharmacy: _____

Marital Status: (Circle) Single Married City:_____

Divorced Widowed Other Family Members: _____

_____

Employer: _____ Referred By:_____

Guarantor (responsible party) Information

Guarantor: _____ Relationship to patient: _____

Address: _____ Responsible Party SSN: _____

_____

Emergency Contact Info:

Contact Name: _____ Home Phone: _____

Relationship to Patient: _____ Cell: _____

Address: _____ Work Phone: _____

_____

Insurance information: *Please provide insurance card and identification to staff at time of registration*

Insurance Co. Name: _____

Insurance Co. Phone: _____

Subscriber (policy holder): _____ Subscribers Relationship to patient:_____

Subscribers Date of Birth: _____ If subscribers address is different than Pt,

Policy ID Number: _____ please show below: _____

Group Number: _____ _____

Group Employer Name: _____

Special Instructions and/ Drug Allergies:_____

Patient/ Responsible Party Signature: _____ Date:_____

Adult Health History

Name:_____ M/F:_____ DOB:_____

Race:_____ Ethnicity:_____ Language:_____

Please list any current or previous medical problems:_____

_____

_____

Do you have a history of any infectious diseases, such as Hepatitis, HIV, etc?_____

_____

Have you had any surgeries? **YES / NO**

If yes, please include type of surgery and dates._____

_____

Does anyone in your family have a history of any medical diseases? Yes / NO

If yes, please include which family member, type of disease, and if they are deceased or living_____

_____

When was your last physical exam?_____

Have you had blood work done in the past year? **YES / NO** If yes, when?_____

Any abnormalities?_____

Do you have any pets? **YES / NO** If yes, how many?_____ Type of Pet(s):_____

Do you have any children? **YES / NO** If yes, how many?_____

Current Employment Status: Full-Time Part-Time Student Retired Self-Employed Unemployed

Do you smoke/dip/chew tobacco? **YES / NO** If yes, how much per day? _____

If yes, when did you start?_____ If no, did you in the past? **YES / NO** When did you quit?_____

Do you drink alcohol? **YES / NO** If yes, how much & how often?_____

Do you wear seat belts? ALWAYS / SOMETIMES / RARELY / NEVER

Do you use sunscreen? ALWAYS / SOMETIMES / RARELY / NEVER

Do you use recreational/street drugs? **YES / NO** If yes, which ones & how often?_____

If no, did you in the past? **YES / NO** If yes, when did you start & quit?_____

Have you ever used marijuana? **YES / NO**

Have you ever thrown up or used enemas or laxatives to lose weight? **YES / NO**

Medication History

Are you currently taking any medication prescribed to you by a doctor? **YES / NO**

If yes, please list them:_____

_____

Are you currently taking any “over the counter” medications or herbal supplements? **YES / NO**

If yes, please list them:_____

_____

Allergies

Do you have any allergies to food?	YES / NO	If yes, please specify:_____
Do you have any allergies to drugs?	YES / NO	If yes, please specify:_____
Do you have any environmental allergies?	YES / NO	If yes, please specify:_____

Immunizations

Tetanus:_____ MMR:_____ Hep A:_____ Hep B:_____

Flu:_____ Pneumovax:_____ Zostavax:_____

Other:_____

MEN ONLY

Are you currently experiencing any of the following symptoms...

Drip or penis discharge?	Y / N	Lumps or swollen glands?	Y / N
Bumps on Penis?	Y / N	Lumps, pain, or swelling of testicles?	Y / N
Difficulty initiating urine stream?	Y / N	Difficulty achieving or maintaining erection?	Y / N
Do you practice testicular self-exams?	Y / N		

What do you currently use for birth control?_____

Women ONLY

Date of last period:_____ Date of last PAP Smear:_____

Any changes with your period?	Y / N	Vaginal itching, burning, or discharge?	Y / N
Bleeding between periods?	Y / N	Bleeding after intercourse?	Y / N
Urine leakage?	Y / N	Pain during or after intercourse?	Y / N
Genital bumps or rash?	Y / N	Menstrual pain?	Y / N
Normal monthly menses?	Y / N	Severity:	Light / Normal / Heavy

Length of cycle?_____ Length of periods?_____

Age when you started menstruating?_____ Currently in menopause?_____

History of abnormal pap?	Y / N	If yes, when?	_____
Currently on birth control?	Y / N	If yes, which one?	_____
Ever been treated for STD/STI?	Y / N	If yes, which one?	_____
Last Mammogram?	Y / N	Perform monthly, self-breast exams?	Y / N

Pregnancy History

How many times have you been pregnant?_____

# of live births?_____ # of miscarriages?_____ # of abortions?_____

Did you have any problems with any of your pregnancies and/or labor/delivery? Y / N

If yes, please explain:_____

_____

_____

For Adolescents/Teenagers ONLY

Do you have any questions about sex, birth control, or STDs/STIs?	YES / NO
Have you ever had sex or plan to have sex in the near future?	YES / NO
Are you happy with the way you look or feel?	YES / NO
Are you having any school-related, learning, or family problems?	YES / NO
Do you have a close friend that you can talk to if you have a problem?	YES / NO

Alcohol Screen

Did you have a drink containing alcohol in the past year? O Yes O No

If Yes: How often did you have a drink containing alcohol in the past year?

O Never (0 point) O Monthly or less (1 point) O 2 to 4 times a month (2 points)

O 2 to 3 times a week (3 points) O 4 or more times a week (4 points)

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

O 1 or 2 drinks (0 point) O 3 or 4 drinks (1 point) O 5 or 6 drinks (2 points)
O 7 to 9 drinks (3 points) O 10 or more drinks (4 points)

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

O Never (0 point) O Less than monthly (1 point) O Monthly (2 points)
O Weekly (3 points) O Daily or almost daily (4 points)

Drugs

Have you used drugs other than those for medical reasons in the past 12 months? O Yes O No
If yes, which ones & how often?_____
If no, did you in the past? **YES / NO** If yes, when did you start & quit?_____

Cultural/Social:

Do you have any children? O Yes O No If yes, how many?_____
Housing: O Apartment O Home Owner O Rent O Other
Living with: O Spouse O Family O Roommate O Parent O Other
Marital status: O Single O Married O Divorced O Widowed
Pets: O Yes O No If yes, how many & what type?_____

Sexual History

Had sex in the past 12 months (vaginal, oral, or anal)? O Yes O No
If Yes: with O Men only O Women only O Both Men and Women
If Yes: Use protection? O Yes O No
Have you ever had a Sexually transmitted disease? O Yes O No
If YES: which ones?_____

Tobacco Use/Smoking

Are you a: O current smoker O current every day smoker O current some day smoker
O Smoker O current status unknown O former smoker
O nonsmoker O unknown if ever smoked O light tobacco smoker
O heavy tobacco smoker

Tobacco use other than smoking:

Do you use tobacco in any other form? O Yes O No

Family History

Does anyone in your family have a history of any medical diseases?
If yes, please include which family member, type of disease, year of birth, and if they are deceased or living:_____

Mother: O Diabetes O Hypertension O Heart Disease O Stroke O Mental Illness
O Cancer O Unknown
Father: O Diabetes O Hypertension O Heart Disease O Stroke O Mental Illness
O Cancer O Unknown

Maternal Grand Mother: O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Maternal Grand Father: O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Paternal Grand Mother: O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Paternal Grand Father: O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown
Siblings: O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Unknown

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the NOTICE OF PRIVACY PRACTICES of COPPELL ASSOCIATES IN FAMILY MEDICINE, P.A.

I understand that COPPELL ASSOCIATES IN FAMILY MEDICINE, P.A. reserves the right to revise its Notice of Privacy Practices at anytime and that I may obtain a copy of the revised Notice Privacy Practices document by forwarding my written request to:

Privacy Officer
COPPELL ASSOCIATES IN FAMILY MEDICINE, P.A.
848 S. Denton Tap Rd., Ste. 100
Coppell, Texas 75019

I understand that full disclosure of COPPELL ASSOCIATES IN FAMILY MEDICINE, P.A.'s privacy practices, and my rights regarding these practices, are contained within the Notice of Privacy Practices document.

I understand that any request for changes or restrictions regarding my rights as described in the Notice of Privacy Practices document must be made in writing to the Privacy Officer.

_____ _____

Patients Name Date

_____ _____

Signature of Parent or Legal Guardian Relationship to Patient

_____

Print name of Legal Guardian if Applicable

PATIENT RELEASE OF INFORMATION

(HIPAA RELEASE)

I _____ give my permission to release any of my medical information to the following persons listed below. This may include family members, friends, and / or associates.

If you choose to not allow anyone access to your medical records, Please write "NONE" and sign and date.

Name	Contact Number

_____ _____

Signature of Patient Date

Please Circle **Either** Do **OR** Do Not On Each Of The Following Sections

I _____ (DO / DO NOT) give my consent for lab results and diagnostic test results to be sent electronically to my **Patient Portal** using the following email address: _____.

I _____ (DO / DO NOT) give my consent for lab results and diagnostic test results to be left on my answering machine / voice mail at the following phone number: _____.

_____ _____

Signature of Patient Date

I understand that both of these authorizations, if signed, are effective for one year from the date signed and that I am to notify Coppell Associates In Family Medicine of any changes I wish to make to this authorization.

Conditions of Admission

Consent for Treatment- Release of Information

I consent to Treatment for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim. **I am also consenting to the release of my information for Electronic Medical Records; including but not limited to, electronic prescribing, downloading insurance benefits, medication history, etc.**

Date:_____ Signed: _____

Relationship to patient: _____

Assignment of Insurance Benefits

I hereby assign, transfer and set over to COPPELL ASSOCIATES IN FAMILY MEDICINE P.A. all of rights, title and interest in my medical reimbursement benefits under my insurance company. This assignment shall remain valid until written notice is given by me.

Date:_____ Signed: _____

Relationship to patient: _____

Thank you for choosing COPPELL ASSOCIATES IN FAMILY MEDICINE P.A. as your healthcare provider. We appreciate the opportunity to assist you with your health care needs.

Our primary objective is to provide quality patient care in an office setting (and hospital when appropriate). We offer complete Family Practice. In order to better assess your medical needs, we will not do referrals without evaluating you in the office to determine if you actually need a referral or have a problem we can take care of. If you need a referral, we can better determine who/what specialty would be most appropriate, we cannot diagnose your condition over the phone. Please allow 2 weeks for the referral process.

On the business side, in order to continue providing quality patient care, payment in some form must be received from each patient to whom services are provided. We are on several managed care plans that we will be happy to file for you. As a condition of accepting your insurance in lieu of payment in full, all copay fees and deductible/co-insurance amounts not satisfied per your insurance company are due at the time of service. Payments from your insurance company are expected within 45 days. After 60 days without a payment from your insurance company or any notification of information needed from them, we will look to you for payment in full.

Because it costs us $10 per statement sent to each patient, we will be adding this as a late charge after 90 days after the first statement of your balance due without the balance being paid.

If you are not on one of the managed care plans for which we are providers, payment in full is expected at the time of service. We will provide you with a statement with the information necessary to bill your carrier. We only bill your primary insurance carriers - we will provide you with a statement and any information necessary for you to file your secondary carrier.

To help us provide care to people who need it, we ask that you cancel your appointment at least 24 hours ahead of time. If you do not, there will be a $30.00 charge for no shows and less than 24-hour cancellations. Please be advised, that after 3 NO SHOW VISITS WITHIN ONE YEAR, you could be discharged.

It is up to you to know your insurance coverage. Guarantor is responsible for giving us the patient's current insurance information, or they will be responsible for paying those charges. Guarantor is responsible for patient's co-pays, any non-covered or denied services, deductibles and/or co-insurances deemed "patient responsibility" by your insurance carrier. This includes anything done in our office as well as lab work or other diagnostic testing. If you have any questions regarding what your insurance covers, you should contact your insurance carrier for details on your specific plan.

Thank you again for your trust in our practice and your cooperation with our payment policy.

Patient Name:_____ Signed: _____

Date:_____ Relationship to patient: _____