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:_____

Infant/Child Health History

Child's Name:_____ M/F:_____ Date of Birth:_____

Race:_____ Ethnicity:_____ Language:_____

Parents' Information

Mother:_____ Father:_____

Address:_____ **Email:**_____

Home #:_____ Mom's Cell #:_____ Dad's Cell #:_____

Mom's Work #:_____ ext:_____ Dad's Work #:_____ ext:_____

Emergency Contact (if unable to reach parents):_____ Relationship to child:_____

Contact Phone #1:_____

Contact Phone #2:_____

(If unable to reach parents & primary emergency contact):

Second Emergency Contact:_____ Relationship to child:_____

Contact Phone #1:_____

Contact Phone #2:_____

Brothers & Sisters (if any): Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Current Health History

Current Medications:_____

Current Medical Problems or Concerns:_____

_____

Drug Allergies? **YES / NO**

Food Allergies? **YES / NO**

Environmental Allergies? **YES / NO**

If yes, please specify:_____

Do you use sunscreen on your child? **Always / Sometimes / Rarely / Never**

Do you use car seats or seat belts? **Always / Sometimes / Rarely / Never**

Does your child attend day care or a similar program? **YES / NO**

Any smokers in the household? **YES / NO**

Any pets in the household? **YES / NO** If yes, how many?_____ Type of pets:_____

For female patients only: Age periods begin:_____

Birth History

Type of Delivery:_____ Birth Weight:_____ Birth Length:_____

Apgar: _____/_____ Term / Preterm

Complications(pregnancy, labor, delivery, or newborn):_____

Medications taken during pregnancy:_____

Growth & Development

Please specify age when child was able to:

Crawl:_____ Sit:_____ Walk:_____ Talk:_____ Toilet Trained:_____

Past Medical History

Previous Illnesses: (chicken pox, mumps, measles, etc.):_____

Please mark those that apply:

Asthma_____ Ear Infections_____ Bedwetting_____ Stuttering_____ Lazy Eye_____

Other:_____

Previous Hospitalizations (please list dates & reason):_____

Previous Surgeries (please list dates & type of surgery):_____

Family History of: (please circle those that apply; include parents, siblings, grandparents, aunts, and uncles)

Diabetes	Thyroid Problems	Migraines/Headaches	Depression	Seizure/Convulsion Disorder
Anemia	Tuberculosis	Lung Problems	Stroke	Mental Retardation
Asthma	Kidney Disease	Heart Problems	Cancer	Learning/Behavioral Problems
Hepatitis	Ulcers	Arthritis	High Blood Pressure	Seasonal Allergies

Vaccination Record

DPT #1 (2mos):_____ DPT #2 (4mos):_____ DPT #3 (6mos):_____

DPT booster (15-18 mos):_____ DPT booster (4-5yrs):_____ DPT booster (14-15yrs):_____

MMR #1 (6mos):_____ MMR #2 (15mos):_____ MMR #3 (5-12yrs): _____

HIB #1 (2mos):_____ HIB #2 (4mos):_____ HIB #3 (6mos):_____

Hep B #1:_____ Hep B #2:_____ Hep B #3:_____

Hep A #1:_____ Hep A #2:_____ Meningococcal:_____

Varicella #1:_____ Varicella #2:_____

Flu Shot:_____

TB Test:_____

OPV/IPV(if applicable):_____

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.

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: _____