COMMUNITY
Family Medicine

New Patient Registration Form
Office Visit

Legal Name:_____ Date of Birth:_____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Social Security Number:_____

Please fill out this form completely and print neatly to help us with your medical care.
Who is your Primary Care Provider?_____

Home Address:_____

Mailing Address (if different):_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email address_____

Gender: ☐ Male ☐ Female Race: ☐ White/Caucasian ☐ Black/ African American ☐ Hispanic ☐ Asian ☐ Other

Insurance

Person Responsible for Bill:_____ Date of Birth:_____

Address:_____ Phone Number:_____

Emergency Contact

Name:_____ Relationship to Patient:_____

Phone Number:_____

What has brought you in to our office today?_____

Medical Information

List any medical problems:

_____

_____

Medications you are currently taking: (if you need more room, please use the back of this sheet)

Name	Strength	Why do you take it?	How often you take it?

Surgeries: (if you need more room, please use the back of this sheet)

Date	Surgery Performed

Do you currently use tobacco? ☐ Yes ☐ No If yes, ☐ Chew ☐ Dip ☐ Cigarettes:___PPD___

☐ Cigars____ ☐ Pipes____

When did you start using tobacco?_____ If you used tobacco in the past, when did you quit?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day?_____

Do you currently use recreational or street drugs? ☐ Yes ☐ No If yes, please list:_____

Family History

THIS INFORMATION MUST BE FILLED OUT COMPLETELY

	Alive	Deceased	Age	Significant Health Problems
Father				
Mother				
Brother				
Sister				
Son				
Daughter				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

Health Habits

Exercise: ☐ No Exercise ☐ Daily Exercise ☐ A Couple Times A Week ☐ Once A Week

Are you on a physician prescribed diet? ☐ Yes ☐ No

How many ounces of water do you drink per day?_____

Number of meals you eat per day:_____

Caffeine:

☐ None	☐ Coffee	☐ Tea	☐ Cola
# of cups per day:			

Do you feel safe at home? ☐ Yes ☐ No

Do you use a seat belt? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have a physical handicap? ☐ Yes ☐ No

Do you have frequent falls? ☐ Yes ☐ No

Do you have vision or hearing loss? ☐ Yes ☐ No

Do you have any artificial body parts? ☐ Yes ☐ No

Physical and/or mental abuse has also been major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Are you sexually active with ☐ Male ☐ Female ☐ Both How many partners?_____

Total number of pregnancies:_____

Total number of live births:_____

The preceding information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Community Family Medicine or insurance company to release any information required to process my claims.

Patient (or Guardian) Signature_____ Date:_____

Copayments

Copayments are due at time of service. If you are unable to make your copayment, we will assist you in rescheduling your appointment.

No Shows, Cancellations, and Being Late

It places undue hardship on other patients when you do not keep your appointment. If you are unable to keep your scheduled appointment, please call the office IMMEDIATELY to let us know. At least 24 hour notice is required. Patients cancelling with less than 24 hours notice will be subject to a $25.00 charge. Upon first failure to keep an appointment without notice, the patient will be subject to a $25.00 charge. Patients missing 2 appointments without notice MAY BE DISCHARGED from the practice. Patients arriving more than 15 minutes late to an appointment will be asked to reschedule.

Community Family Medicine

Patient Authorization for Use and Disclosure of Protected Health Information By signing, I authorize **Community Family Medicine** to use and/or disclose certain protected health information (PHI) about me to:

☐ I do not authorize any one to receive information regarding my health care.

☐ I authorize only the following person(s) to receive information regarding my health care.

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

This authorization permits **Community Family Medicine** to use and/or disclose the following individually identifiable health information about me:

Mark all that apply: Labs___ Radiology results ___ Medications ____ All records____

Please note: Community Family Medicine communicates health care information with the patient through both **mail** and the **telephone.**

I allow Community Family Medicine to contact me in regards to my healthcare and labs in the following ways: **(Please Circle)**

Voicemail and/or Mail

Authorization to Pay Benefits & Acceptance of Payment Policy

I authorize payment directly to Community Family Medicine for any surgical or medical benefits payable to me for services provided. I understand that I am responsible for payment for the services provided by Community Family Medicine. Community Family Medicine will file the charges with my insurance plan. I accept responsibility for those charges not covered by my plan, and I agree to pay those charges on receipt of statement. I understand that I am responsible for any co-payment due at time of service. I authorize Community Family Medicine to release any information acquired in the course of my examination or treatment for insurance purposes.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization expires when; (1) minor child turns 18, (2) Patient would like to make changes due to a change in a life event, (3) Provider, patient relationship is terminated.

Community Family Medicine
2469 Wendell Blvd
Wendell NC 27591

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient Name or Legal Guardian Date

COMMUNITY FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____

_____