GRIFFIN FACULTY PHYSICIANS

Patient Registration Form

Last Name: _____

First Name: _____ MI:__

DOB:____/____/_____ Gender(circle): M F

SSN: _____-___-_____

Address: _____

Address (cont): _____

ZIP:_____

City: _____

State:_____

Occupation:_____

Employer: _____

How did you hear about us? _____

Home Phone: _____-_____-_____

Cell Phone: _____-_____-_____

Can we send automated reminders via Text/Cell?
YES NO

Contact Preference (circle):
Home Work Mobile Mail Portal

Email: _____

Marital Status (circle):
Married Single Divorced Separated Widowed

Preferred Language: _____

Race: _____

Ethnicity: _____

If Hispanic/Latino Origin, please specify origin:
_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____-_____-_____

Mobile Phone: _____-_____-_____

ADDITIONAL INFORMATION

Preferred Pharmacy:_____

Preferred Lab: _____

Preferred Imaging Facility: _____

Primary Care Provider:_____

Referring Provider: _____

INSURANCE INFORMATION

Primary Insurance: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____

ID Number: _____ Group Number: _____

Tertiary Insurance: _____ ID:_____ Group Number: _____

GRIFFIN FACULTY PHYSICIANS

NAME: **DOB:**

Reason for your visit today?
Are you in any pain? Y/N
Advanced Directives
None Do Not Resuscitate Durable Power of Attorney Living Will HC Proxy
Date Reviewed:

Care Team-List any other providers you see:	
PCP:	Other:
Cardiologist:	Other:
Ob/Gyn (Female):	Other:

Medications – List all medications you take, prescription and non-prescription, and the dosage	
I do not take any medications __	
Medication Name & Dosage (mg,mL,etc.)	**Direction (once a day, twice a day, etc.)**

Allergies-Medication/Food – List all known allergies (drugs, food, animals, etc.)	
No Known Allergies __	

Vaccine History

Vaccine	**Year**	**Vaccine**	**Year**
Influenza		Varicella/Chickenpox	
Tetanus (Td)		MMR	
Teatanus w/Pertussis (Tdap)		Hep B	
Pneum		Other:	

GYN History

	Date		**Date**
Last Menstrual Period		Age at menarche (first period)	
Current Birth control method		Age at menopause	
Last breast exam		Any post menopausal bleeding? Yes No	
Last mammogram		Do you perform self-breast exams? Yes No	
Last mammogram normal?		Are you considering pregnancy? Yes No	
Last pap smear		Number of pregnancies?	
Last bone density test		Number of live births?	

GRIFFIN FACULTY PHYSICIANS

NAME: **DOB:**

Family History – Check if any family member(s) has had any of the following conditions.

Adopted __

Diagnosis	Mother	Father	Brother	Sister	Other
Alcoholism					
Alzheimer's Disease					
Asthma					
Blood Disease					
CVA (Stroke)					
CAD (Heart Attack)					
Cancer – Type:					
COPD / Lung disease					
Congestive Heart Failure					
Depression /Depressive Disorders					
Diabetes					
Hyperlipidemia (High Cholesterol)					
Hypertension (High Blood Pressure)					
Thyroid disorder: Hyper Hypo					
Irritable Bowel Disease					
Obesity					
Osteoarthritis					
Osteoporosis					
PVD					
Renal Disease					
Other					
Other					

Surgical History – Check if you have received the following procedures, and year performed.

Surgical Procedure	Year	***Surgical Procedures***	Year
None		Shoulder	
Amputation		Spine	
Angioplasty/PTCA		Tonsillectomy	
Appendectomy		Tracheostomy	
Arthroscopy		Transplant	
Back Surgery			
Bowel/Colon surgery		***Male Only***	
Carpal Tunnel		Prostate Biopsy	
Cataract Extraction		TURP	
Cholecystectomy		(Trans-urethral resection of Prostate)	
Colonoscopy		Vasectomy	
Colostomy / Colectomy		Other	
Gastric Bypass		***Female Only***	
Hernia Repair		Augmentation Mammoplasty	
Hip Replacement		Bilateral Tubal Ligation	
Knee Replacement		Breast Biopsy	
LASIK		Cesarean Section	
Liver Biopsy		D and C	
Pacemaker		Hysterectomy	
Nephrectomy / Kidney		Mastectomy	
Thyroidectomy		Other	

GRIFFIN FACULTY PHYSICIANS

NAME: **DOB:**

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
None		Gout	
Acid Reflux		Heart Attack	
Alcoholism/Substance Abuse		Heart Disease	
Angina		Hemorrhoids	
Anxiety		High Blood Pressure	
Arthritis		High Cholesterol	
Asthma		Intestinal Problems-Ulcer, Hiatal Hernia	
Arrhythmia		Jaundice or liver disease	
Benign Prostatic Hypertrophy		Kidney disease or problems	
Blood Disorders		Lung Disease-Pneumonia, TB, Emphysema	
Cancer – Type		Lyme Disease	
Colitis		Migraine Headaches	
Colonoscopy		Palpitations	
Congestive Heart Failure (CHF)		Obesity	
COPD (Emphysema)		Osteopenia or Osteoporosis	
Depression		Seizures, Convulsions, Epilepsy	
Diabetes		Sickle Cell Anemia	
Diverticulitis		Sleep Apnea	
Fainting Spells		Stroke	
Fibromyalgia		Thyroid	
Gallstones		Venereal Disease	
Glaucoma		Vitamin Deficiency	

Social History *(please circle)*

Do you have children? Yes No	How many?		Female(s)	Male(s)
Tobacco Use	Never Daily Weekly Less Former/Year quit:		Chewing Cigar Dip E-Cig Hookah Pipe Snuff Cigarette How many Packs per Day?	
Have you ever been offered smoking cessation? Yes No	*Are you interested in more information?*			
Alcohol Intake	None Occassional Moderate Heavy Years of use:		Beer Wine Liquor Other:	
Drug/Substance	Never Daily Weekly Less Former/Year quit:		Pills Marijuana Cocaine Heroin Other:	
General Stress	Low Medium High			
Diet	Regular/no restrictions Diabetic Vegan Vegetarian Gluten free Other:			
Exercise Activity	None Occassional Moderate Heavy # _____Days/Week			
Caffeine Use	Never Daily Weekly Less Former/Year quit:		Chocolate Coffee Soda Tea Tablets Other:	
Are you sexually active? Yes No	**Do you practice safe sex?** Yes No Sometimes			
Gender identity	Male Female Neither exclusively Male nor Female Choose not to disclose			
Sexual Orientation	Heterosexual Gay Lesbian Bisexual Choose not to disclose			
Do you have any concerns with meeting any of the following ? *(if so please circle all that apply)*	Food Housing Transportation Childcare Heating Other:			
Do you feel safe at home? Yes No *Yes more information:*				

GRIFFIN FACULTY PHYSICIANS

PATIENT ACKNOWLEDGMENT FORM

Patient Name: _____ Patient DOB: _____

CONSENT TO TREAT

Purpose: Permits Griffin Faculty Physicians to provide patient care.

Consent to treatment and services: I agree ("consent") to medical treatment or services that my physician considers necessary. Those services include, but are not limited to, diagnostic examinations, consult services, routine office visits, and laboratory procedures (including blood work and EKG's). If appropriate, I also consent to examination of my specimens, imaging studies, and other tests or studies by healthcare personnel or entities other than Griffin Faculty Physicians. I understand that this consent, or any part of it, may be revoked by me at any time but that the Practice is entitled to rely on the consent I have given until it has been revoked.I give Permission to consult with relevant specialists including behavioral health. This consultation could include face to face or non face to face services.

Signature of Patient/Responsible person: _____ Relationship to Patient: _____

Patient/Responsible person unable to sign for reason: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS INFORMATION

Purpose: Confirms that Griffin Faculty Physicians has complied with its obligation to provide patients with an explanation of its privacy practices under the Health Insurance Portability and Accountability Act (HIPAA) and that the information on the rights of patients was provided.

Printed copy available to patient per request:

Initials:

RELEASE OF INFORMATION FOR INSURANCE, ASSIGNMENT OF BENEFITS, AND APPEAL PROCESS

Purpose: Permits Griffin Faculty Physicians to release patient information for purposes of obtaining payment for care provided.

Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided, and healthcare operations.

Release to insurer: I understand that *Griffin Faculty Physicians* and/or, entity, or organization providing medical services to me may release information to my insurance carrier(s) to substantiate payment for hospitalization and medical care, or employers (and/or their insurance carriers) in Workers' Compensation matters. Such persons or entities are permitted to examine and obtain necessary information from my medical records in accordance with applicable law related to patients' confidential health information and the policies of *Griffin Faculty Physicians*.

Assignment of benefits: I assign to *Griffin Faculty Physicians* and/or-entity, or organization providing medical services to me any and all benefits, including payment, to which I may be entitled. Payments include those from any government agency, insurance carrier, or others financially responsible for the medical care rendered to me or my dependent.

Appeal: I agree that *Griffin Faculty Physicians* may appeal any disallowance of payment by my insurance company for care received.

Initials:

GRIFFIN FACULTY PHYSICIANS

MEDICARE INSURANCE

Purpose: Permits the hospital to receive payment from Medicare.

Certification of accuracy: I certify that the information I have provided for the purpose of applying for payment under title XVIII of the Social Security Act is accurate.

Authorization to release information: I understand that any holder of my medical or other information regarding my treatment may release to the Social Security Administration and/or the Centers for Medicare & Medicaid Services, or its intermediaries or carriers, any necessary information needed in relation to a Medicare claim.

Request for payment: In relation to a Medicare claim, I request that payment of authorized benefits be made on my behalf.

Assignment of Medicare benefits: I assign the Medicare benefits payable for physician services to the physician, entity, or organization furnishing the services or authorize such physician, entity, or organization to submit a claim to Medicare on my behalf.

Initials: _____

FINANCIAL AGREEMENT/GUARANTEE/COLLECTION

Purpose: The patient accepts responsibility for payment of co-payments and services not covered by insurance or other payor.

For services rendered or to be rendered, I, for myself and my representatives, promise to pay to *Griffin Faculty Physicians* and/or any physician, entity, or organization providing medical services to me, the full and entire amount of any and all bills not paid by any insurance plan, private or governmental, or combination of plans, including any required deductible and/or co-pay amounts. I understand that all such bills are due and payable upon request. Payment may be required at any time from the undersigned Guarantor and the practice's failure to demand payment shall not be a prerequisite to the guarantor's immediate responsibility for payment. In the event this account is referred for collection, I/we understand and agree to pay in addition to the above, all costs, fees, court and attorneys' fees.

Guaranty of payment: I agree that if all or part of my medical bill is not covered by any medical insurance plan, or Worker's Compensation insurance, payment of the balance shall be due immediately on notice.

Initials: _____

AUTHORIZATION TO OBTAIN MEDICATION HISTORY INFORMATION

Please initial in **ONE** of the boxes to indicate your authorization:

( ) I hereby DO authorize Griffin Faculty Physicians to OBTAIN my medication history electronically from my insurance to better facilitate my care. I understand the initial medication history download includes data from the past two years and that medication information will update periodically in the future.

( ) I hereby DO NOT authorize Griffin Faculty Physicians to **OBTAIN** my medication history electronically from my insurance.

I/WE AGREE AND ACCEPT THE INITIALED TERMS OF THIS DOCUMENT.

_____ **Relationship to Patient:** _____

Signature of Patient or Responsible Person (Guarantor)