# REGISTRATION FORM

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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | PCP: | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | First: | | | Middle: | | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | | | Marital status (circle one) | | | | | |
|  | | | | | | | | | | Single / Mar / Div. / Sep / Wid | | | | | |
| Is this your legal name? | | | If not, what is your legal name? | | | (Former name): | | | | | | | | | | | Birth date: | | | | Age: | Sex: | | |
| ❑ Yes | | ❑ No |  | | |  | | | | | | | | | | | / / | | | |  | ❑ M | ❑ F | |
| Street address: | | | | | | | | | Social Security no.: | | | | | | | | | | Home/Cell phone no | | | | | |
|  | | | | | | | | |  | | | | | | | | | | ( ) | | | | | |
| Email Address | | | | City: | | | | | | | | State: | | | | | | | | ZIP Code: | | | | |
|  | | | |  | | | | | | | |  | | | | | | | |  | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | | | | Employer phone no.: | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | Relationship to patient: | | | | | | | | Home phone no.: | | | | | | Work phone no.: | | | |
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|  | | | | | | |  | | | | | | | |  | | | | | |  | | | |
| The above 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 Excel Medical Center or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | | |  | | | | | | | |  |
|  | Patient/Guardian signature: | | | | | | | | | | | |  | | | Date: | | | | | | | |  |

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | | |
| Previous Name: | | | | | | |  | | | | Social Security #: | | | |  | | | | | |
| I request and authorize | | | | | | | | | |  | | | | | | | | | | to |
| release healthcare information of the patient named above to: | | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | | EXCEL MEDICAL CENTER | | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | | |
|  | | City: | | | PHILADELPHIA | | | | | | | State: | PA | | | Zip Code: | | |  | |
|  | | Fax: | | |  | | | | | | | Phone: |  | | | | | | | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | | |
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| Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. ***(Make Change when necessary)*** | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. | | | | | | | | | | | | | | | | |
| Patient Signature: | | | | | | | |  | | | | | Date Signed: | | | | |  | | |

**Payment Policy**

Thank you for choosing Excel Medical center as your primary care facility. We are committed to providing you with quality and affordable health care. Please read, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan accept, payment in full in expected at each visit. If you are insured by a plan we do accept, but your information has not been up-dated, full payment is expected until we can verify your coverage. Your insurance benefits are your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-payments and deductibles.** All Co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please be aware of and prepared to pay you co-pay or deductible at the time of you appointment.

**Non-covered services.** Please be aware that some and perhaps all of the service you receive may be no covered or not considered reasonable or necessary by Medicare or other insurances. You must pay for these services in full the time of your visit.

**Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**Claims Submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that they balance of your claim is your responsibility: whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefit. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During the 30 day period, our physician will only be able to treat you on an emergency basis.

**Missed appointment.** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments, we have instituted a $25 no show fee. We request a 24-48-hour advanced notice for appointment cancellations. Failure to do so will result in a $25 fee charged to your account.

Our practice is committed to providing the best treatment to our patients. Our prices are represented of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understanding the payment policy and agree to abide by its guidelines:

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Signature or patient or responsible party Date

**Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is provided in two layers. This top layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures. How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

**Your Rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we must charge you a cost-based fee. You also have the right to request list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

**Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.

**Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to the U.S. department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions, feel free to contact the Office manager.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date, below, to acknowledge that you have received both layers of this Notice of Privacy Practices.

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Name of PATIENT (PRINT) Signature of Patient Date

**MEDICAL HISTORY**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medication History**  **List you prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | | | | | | | | | | | | | | | | |
| *Name of Drug* | | | | *Strength* | | | | | | | *Frequency taken* | | | | | | |
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| **Allergies to Medications** | | | | | | | | | | | | | | | | | |
| *Name of Drug* | | | | | | | | *Reaction you had:* | | | | | | | | | |
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| **Vaccinations**  **Have you recently received any vaccinations?**  **If yes, please state what was given, when it was administered and where it was administered.** | | | | | | | | | | | | | | | | | |
| *Vaccine Name* | | | *Date Administered* | | | | | | | | *Location Administered* | | | | | | |
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| **HEALTH HABITS AND PERSONAL SAFETY** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| ***All questions contained in this questionnaire are optional and will be kept strictly confidential*** | | | | | | | | | | | | | | | | | |
| Do you have children? (Of any age) | | | | | | | If yes, how many: | | | | Boys: | | Girls: | | | | |
| ***Exercise*** | Do you Exercise? | | | | | | | | | | | | | | Yes | | No |
| If yes, How often? | | | | | | | | | | | | | | | | |
| If yes, What types of exercises? | | | | | | | | | | | | | | | | |
| ***Pets*** | Do you have any pets? | | | | | | | | | | | | | | Yes | | No |
| If yes, What type/How many? | | | | | | | | | | | | | | | | |
| ***Sexual History*** | Are you sexually active? | | | | | | | | | | | | | | Yes | | No |
| If yes, are you trying for a pregnancy? | | | | | | | | | | | | | | Yes | | No |
| If not trying for pregnancy list contraceptive or barrier method used: | | | | | | | | | | | | | | | | |
| Any discomfort during intercourse? | | | | | | | | | | | | | | Yes | | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AID, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | | | | | | | | | | | | Yes | | No |
| ***Diet*** | Are you dieting? | | | | | | | | | | | | | | Yes | | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | | | | | | | | Yes | | No |
| # of meals you eat on an average day | | | | | | | | | | | | | | | | |
| Rank of salt intake | | | | | High | | | | Medium | | | | Low | | | |
| Rank of fat intake | | | | | High | | | | Medium | | | | Low | | | |
| ***Caffeine*** | None | | | | Coffee | | | | | Tea | | | | Soda | | | |
| # of cups/cans/bottles per day | | | | | | | | | | | | | | | | |
| ***Drugs*** | Do you currently use recreational or street drugs? | | | | | | | | | | | | | | | Yes | No |
| Have you ever given yourself street drugs with a needle? | | | | | | | | | | | | | | | Yes | No |
| ***Alcohol*** | Do you drink alcohol? | | | | | | | | | | | | | | | Yes | No |
| If yes, what kind? | | | | | | | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | | | | | | | | | Yes | No |
| Have you considered stopping? | | | | | | | | | | | | | | | Yes | No |
| Have you ever experiences blackouts? | | | | | | | | | | | | | | | Yes | No |
| Are you prone to “binge” drinking? | | | | | | | | | | | | | | | Yes | No |
| ***Tobacco*** | Do you use tobacco? | | | | | | | | | | | | | | | Yes | No |
| Cigarettes – pks/day | | | | | | | | Chew - #/day | | Pipe - #/day | | Cigars - #/day | | | | |
| # of years smoking | | | | | | | | | | Or quit year | | | | | | |
| ***Personal Safety*** | Do you live alone? | | | | | | | | | | | | | | | Yes | No |
| Do you have frequent falls? | | | | | | | | | | | | | | | Yes | No |
| Do you have vision or hearing loss? | | | | | | | | | | | | | | | Yes | No |
| Do you have an Advance Directives and/or living will? | | | | | | | | | | | | | | | Yes | No |
| Would you like information on the preparation of these? | | | | | | | | | | | | | | | Yes | No |
| Physical and/or mental abuse have also become major public health issue in the country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with the provider? | | | | | | | | | | | | | | | Yes | No |
|  | | | | | | | | | | | | | | | | | |
| **HEALTH HISTORY** | | | | | | | | | | | | | | | | | |
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| ***Past Medical History*** **(Do you currently have or have you ever had any of the following):** | | | | | | | | | | | | | | | | | |
| Diabetes | | High Blood Pressure | | | | | | | Heart Condition | | | Seizures | | | | | |
| Blood Disorder | | Blood Clots | | | | | | | Stroke | | | Cancer | | | | | |
| Asthma | | Mitral Valve Prolapse (heart murmur) | | | | | | | Heart Attack | | | Other: | | | | | |
|  | | | | | | | | | | | | | | | | | |
| ***Past Surgical History* (Have you had any of the following surgeries):** | | | | | | | | | | | | | | | | | |
| Hysterectomy | | | | Bladder Surgery | | | | | | | Surgery for Urinary Incontinence | | | | | | |
| Surgery on the Ovaries | | | | Endometriosis Surgery | | | | | | | C-Section | | | | | | |
| Tubal Ligation | | | | Appendectomy | | | | | | | Gallbladder Surgery | | | | | | |
| Ectopic Pregnancy | | | | Hernia Surgery | | | | | | | Cancer Surgery | | | | | | |
| Other: | | | | Other: | | | | | | | Other: | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| ***Family Medical History* (Choose all illnesses that a member of your family has/had):** | | | | | | | | | | | | | | | | | |
| High Blood pressure | | | | Diabetes | | | | | | | Uterine Cancer | | | | | | |
| Ovarian Cancer | | | | Cervical Cancer | | | | | | | Colon or Rectal Cancer | | | | | | |
| Breast Cancer | | | | Other: | | | | | | | Other: | | | | | | |