KELLIWOOD FAMILY PRACTICE
REGISTRATION FORM

Date: ______________________________________ Home Phone (___) ____________________

-PATIENT INFORMATION-

Name ____ SS/HIC/Patient ID ___________________________ Last Name

First Name Middle Initial

Address ____ Cell Phone (___) _______________________

City _____________________________________ State ___________________ Zip _______________________

Sex M F Age _______ Birth Date _____________ Married Widowed Single Minor
Separated Divorced Domestic Partnership

Patient Employer/School ____ Occupation _______________________

Employer/School Address _________________________________ Employer/School Phone (___) _________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? _______________________________ Phone (___) ___________________

Person Responsible for Account ____

Last Name First Name Middle Initial

Relation to Patient ______________________________ Birth Date ___________________ SS# __________________

Address (if different from patient's) __________________________________ Phone (____) _______________________

City ___________________________________ State ______________________ Zip _______________________

Responsible Party's Employer ____ Occupation __________________

Business Address _______________________________________ Business Phone (___) _________________________

Insurance Company ____ Contact Phone (___) _______________________

Subscriber # ____ Group # _______________________________

Is patient covered by additional insurance? Yes No

Subscriber Name ____________________________ Relation to Patient ________________ Birth Date ______________

Address (if different from patient's) ___________________________________ Phone (____) _____________________

City ___________________________________ State ______________________ Zip _______________________

Subscriber's Employer ____ Business Phone (___) _______________

Insurance Company ____ Contact Phone (___) _______________________

Subscriber # ____ Group # _______________________________

~ASSIGNMENT AND RELEASE~

I certify that I, and/or my dependent(s), have insurance coverage with the above mentioned insurance carrier and assign directly to Kelliwood Family Practice all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ Date_____________________________________

Signature of Patient, Parent, Guardian or Personal Representative

____ Relationship to Patient ____________________________

Please print name of Patient, Parent, Guardian or Personal Representative

Confidential

Patient Name____ Today's Date________________

Age_____ Birth Date__________ Date of last physical examination____________________________

What is your reason for visit? ____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent
- ☐ Lack of bladder control
- ☐ Painful urination

GASTRONITESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heat

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between cycle
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period____________

Date of last Pap Smear___________

Have you had a mammogram? ________

are you pregnant? ______

Number of children____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tonsillitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease.

Medications

List medications you are currently taking.

____

____

Pharmacy Name______________________Phone________________________

Allergies

____

____

____

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of Death		Please indicate if, your blood relatives had any of the following: Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? □ Yes □ No

If yes, please give approximate date ____________________________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupation

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

To the best of my knowledge, the above information is complete and correct; I understand that it is my responsibility to inform my doctor if I, or my minor child, ever had a change in health

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Please print name of Patient, Parent, Guardian or Personal Representative

____
Relationship to Patient

KELLIWOOD FAMILY PRACTICE

Authorization of Use and Disclosure of Protected Health Information

APPOINTMENT REMINDERS, LABORATORY RESULTS, BILLING ISSUES

This office may use your information to notify you of any changes in your scheduled appointment, to inform you of your lab results and/or physician instructions and to discuss billing issues pertaining to your healthcare.

Please indicate how you would like to be notified with the information.
(Check all that apply)

______Home Telephone #____________________________

______Cell Phone#__________________________________

If you have an answering machine, may we leave detailed messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided by Kelliwood Family Practice?
______YES ______NO

______Work Telephone

______Work voice mail May we leave detailed messages? _______Yes _______No

______Fax lab results to:_____________________________(Fax number)

______You may discuss any of my medical information with the following emergency contacts:

Name	Relationship	Telephone

Patient Name (Please print) ____________________ Date of Birth ____________________

Patient/Guardian Signature ____________________ Date ____________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION to KELLIWOOD FAMILY PRACTICE

Patient Name:_______________________________________Date of Birth:_______________

Address:____Telephone #:_______________

City State Zip:_______________________________________

I hereby authorize:

KELLIWOOD FAMILY PRACTICE
STEVEN C. SPENCER, M.D.

to disclose information from my/my minor child's medical record to:

Name: ____

Address: ____

City, State, Zip: _______________________________________

This information is needed for the following reason:

____

The specific information I wish to have released is:

_______ LAB AND DIAGNOSTIC REPORTS ONLY   ________ IMMUNIZATION RECORDS

_______ ALL MEDICAL RECORDS

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for one year from the date it is signed.

______________________________________   ___________________
Signature: (Parent or Legal Guardian if minor)   Date:

______________________________________   ___________________
Witness: Expiration date:

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released.
_______I DO consent   _______I DO NOT consent to have this information disclosed.

______________________________________   ___________________
Signature: (Parent or Legal Guardian if minor)   Date:

This medical record may contain information concerning HIV testing and/or AIDS diagnosis treatment. Separate consent must be given before this information can be released.
_______I DO consent   _______I DO NOT consent to have this information disclosed.

______________________________________   ___________________
Signature: (Parent or Legal Guardian if minor)   Date:

Appointments Policy

- Office visits are by appointment only.
- Office Hours: Mon – Fri 8:30 a.m. – 5:00 p.m.
- New patients should arrive 20 minutes prior to appointment time to complete registration process for first-time patients.
- Established patients scheduled for a physical should arrive 10 minutes prior to appointment time.
- Please provide any insurance or address/contact changes at the time you schedule your appointment.
- Please bring a list of all medications or actual medication bottles.
- Please provide 24 hours notice for cancellations or to re-schedule your appointment.
- If you have a last minute emergency, which prevents you from keeping your appointment, please contact our office immediately.
- Our office makes every effort to accommodate same day urgent visits for our patients. Due to scheduling, we can only accommodate a certain number of urgent visits per day; therefore contact our office as early as possible.
- If you arrive more than 15 minutes late for your appointment, without prior notice, we will make every effort to work you into our schedule. Out of courtesy to our other patients, we may ask you to reschedule the appointment.
- If you are scheduled for a yearly physical exam, you should be fasting. Please refrain from eating or drinking (except water) for AT LEAST 8 HOURS prior to your appointment.
- Our registration form for new patients and a medication log can be found in the patient forms section at our website, http://www.kelliwoodfp.com, for your convenience.

Prescription Policy

- Non-urgent refills needing physician approval should be requested by contacting your pharmacy 48 business hours in advance.
- All prescriptions for pain medications, narcotics, and any other potentially addictive medication require an office visit evaluation.
- Previously undiagnosed problems or changes in your health will not be treated via phone or internet. Please make an appointment so that we may assess your problem with the attention your health deserves.
- All triplicate prescription refill requests should be requested 48 business hours in advance and a $10.00 fee is assessed for these prescriptions. This fee is due prior to the prescription release.
- Lost/misplaced prescriptions will be replaced upon request, with physician approval. A $10.00 fee will be assessed and is due prior to the prescription release.
- Please do not call after hours for routine prescription refills.

Financial Policy

- All copayments, coinsurance, deductibles, and all patient portions are due at the time of service.
- Our office accepts American Express, Visa, Mastercard, cash and checks. There is a fee of $35.00 for returned checks.
- Insurance verification is not a guarantee of payment, patient is ultimately responsible for any unpaid or denied services.
- If our office is unable to verify insurance benefits, payment in full will be due at the time of service.
- Our office assesses a $25.00 fee for failure to keep your appointment without 24 hour notification.

I have read and understand the Appointment and Prescription Policies of Kelliwood Family Practice.

Print Name ____

Signature ____ Date ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details)*

____

____

____

____________________________________ ________________

Employee signature Date