

Patient Registration Form

PATIENT INFORMATION

Physician _____

(Please Print)

 Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated OtherSocial Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day EveningCellular _____ Pager _____ May we contact you at work? Yes No

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

Do You Have A Living Will? Y N

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (_____) _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

StoneCrest Family Physicians

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **StoneCrest Family Physicians** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **StoneCrest Family Physicians** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **StoneCrest Family Physicians**.

I acknowledge that I have been given the **StoneCrest Family Physicians** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date

Child's Birth History

Was the child born premature? _____ If so, how early? _____ Was the child required to stay in intensive care unit?
_____ If so, how long? _____ Was the child delivered by C-section? _____
If so, what was the reason?

Past Medical History

Has your child ever been in the hospital? _____ If so, why? _____

Has your child ever had surgery? _____ If so, what kind? _____

Please indicate if your child has had any of the following conditions (circle):

Diabetes	High blood pressure	Heart disease	Lung disease
Kidney disease	Seizures	Asthma	Measles
Tuberculosis	Mumps	Chicken Pox	Urinary tract infection
Cancer	Other (please specify): _____		

Medications/Allergies

Please list any medications that your child is currently taking (prescription or over-the-counter): _____

Is your child allergic to any medications? _____ If so, please list them: _____

Immunizations

Is your child up to date on his/her immunizations? _____ (Please provide us with a copy of your child's immunization record)

Family Medical History

Please indicate if your child has any blood relatives with the following conditions (circle):

Diabetes	High blood pressure	Heart disease	Lung disease
Kidney disease	Seizures	Asthma	Cancer
Other (please specify): _____			

Please list the names and ages of the child's brothers and sisters:

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Social History

Who does the child live with?

Does anybody at home smoke? _____ If so, who? _____

What school/day care does your child attend? _____

Does your child have any special interests/hobbies? _____ If so, what are they? _____

Please give any information not asked above that you believe is important: _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance, however you are responsible for your copay and/or percentage which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 45 days you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature

Date

Witness

AUTHORIZATION OF TREATMENT

Medical care or immunizations cannot be given unless my child is accompanied by one of the following:

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center of Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these tests results to the person who is exposed to my child's body fluids.

Parent / Guardian's Signature

Relationship

Date