Patient Registration Information

Please PRINT AND complete ALL sections below!

Patient's Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

Patient 's / Responsible Party Information

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: ____ City: _____ State: ____ Zip: _____

Patient's Insurance Information

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

Patient's Referral Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Pharmacy Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to FAMILY MEDICINE SPECIALISTS and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

PATIENT HISTORY

Name _____ Date of Birth _____ Social Security _____

Occupation _____ Education (# of years completed) _____

Do you have any financial concerns about your healthcare? ❑ No ❑ Yes _____

ADVERSE REACTIONS

Drugs (Please Specify)		Foods (Please Specify)	
_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
❑ Iodine / Shellfish	Reaction _____	❑ Bee Stings/Insect Bites	Reaction _____
❑ Latex	Reaction _____	❑ Adhesive Tape	Reaction _____

CURRENT MEDICATIONS

Please include over-the-counter medications

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

IMMUNIZATIONS

Please Indicate Date of Last Injection

❑ Pneumonia _____	❑ Diphtheria _____	❑ Pertussis _____
❑ MMR _____	❑ Polio _____	❑ Tetanus _____
❑ Flu _____	❑ Hepatitis A _____	❑ Hepatitis B _____
❑ TB Test _____	❑ Varivax _____	

HOSPITALIZATION OR SURGERY

DATES / REASON	DATES / REASON
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY *(check all that apply)*

❑ Headaches	❑ Congenital Heart Disease	❑ Liver Disease	❑ Menstrual Dysfunction
❑ High Blood Pressure	❑ Rheumatic Fever	❑ Ulcer	❑ Epilepsy
❑ Stroke	❑ Scarlet Fever	❑ Gout	❑ Depression
❑ High Cholesterol	❑ Allergies / Hay Fever	❑ Bowel Irregularity	❑ Arthritis
❑ Chest Pain / Angina	❑ Asthma	❑ Shortness of Breath	❑ Dizziness / Fainting
❑ Congestive Heart Failure	❑ Emphysema	❑ Diabetes	❑ Prostate Disease
❑ Heart Palpitations	❑ Sexual Dysfunction	❑ Anemia	❑ Thyroid Disease
❑ Heart Murmur	❑ Venereal Disease	❑ Previous Blood Transfusion	❑ Bladder Dysfunction
❑ Heart Attack	❑ Positive TB Screening	❑ Aids / HIV	❑ Cancer (type): _____
	❑ Glaucoma	❑ Hearing Loss	❑ Other: _____

FAMILY HISTORY

Has any blood relative had any of the following? Check all that apply and list which family member.

❑ Alzheimer's Disease _____	❑ Anemia _____	❑ Asthma _____	❑ Bleeding Tendency _____
❑ Allergies _____	❑ Diabetes _____	❑ Alcoholism _____	❑ Heart Disease _____
❑ High Cholesterol _____	❑ Blindness _____	❑ Kidney Disease _____	❑ Mental Health Disorder _____
❑ Memory Loss _____	❑ Epilepsy _____	❑ Osteoporosis _____	❑ High Blood Pressure _____
❑ Stroke / CVA _____	❑ Cancer (type) _____	❑ Hearing Loss _____	❑ Other _____
❑ Neurological Disorder _____	_____	❑ Tuberculosis _____	_____

FUNCTIONAL ASSESSMENT

What is the easiest way for you to learn new things? ❑ Reading ❑ Listening ❑ Pictures ❑ Demonstration ❑ Video
Do you have any difficulty with reading or writing? ❑ No ❑ Yes (explain): _____
Do you have any problems with: ❑ Vision ❑ Hearing ❑ Speech ❑ Walking ❑ Lifting
Do you have any religious or cultural beliefs/values we should be aware of as we provide your care? ❑ No ❑ Yes (explain): _____

Are you experiencing any stress/stressful situations? ❑ No ❑ Yes (explain): _____

Have you experienced any traumatic or abusive situations? ❑ No ❑ Yes (explain): _____

Do you live alone? ❑ No ❑ Yes Who is your Caregiver? _____

NUTRITIONAL ASSESSMENT

Without trying, have you gained/lost 10 pounds or more in the last six months? ❑ No ❑ Yes
Are you worried about a possible eating disorder? ❑ No ❑ Yes
Do you avoid or not eat meat, dairy products, or fruits/vegetables? ❑ No ❑ Yes
Do you take any herbal, vitamin/mineral, or nutritional drinks or supplements? ❑ No ❑ Yes

HABITS *(check all that apply)*

❑ Smoke (if yes): Packs Daily _____ Stopped When: _____
❑ Coffee or other Caffeinated Drinks (if yes): How many daily _____
❑ Exercise Routine (if yes): _____ Type: _____
❑ Difficulty Falling Asleep _____
❑ Contact with Blood/Body Fluid at Work: _____
❑ Recreational/Street Drug Use (specify): _____
❑ Alcohol (if yes): Type: _____ Amount: _____

❑ Other Tobacco Products _____
❑ Diet: Salt Intake _____
❑ Snoring _____
❑ Special Diet _____
❑ HIV Exposure/Risk _____
❑ Seat Belts _____
❑ Daily ❑ Weekly ❑ Socially

MEN ONLY

Date of last rectal exam: _____
Sexually active: ❑ No ❑ Yes
Practice safe sex: ❑ No ❑ Yes

Date of last PSA: _____
Monthly Testicular self exam: ❑ No ❑ Yes

WOMEN ONLY

Last menstrual period: _____
Age at onset: _____ ❑ Regular ❑ Irregular
Flow: ❑ Heavy ❑ Moderate ❑ Light
Pain/Cramps with menses: ❑ Yes ❑ No
Days of flow: _____
Length of cycle: _____
Last pap smear: _____
Last Mammogram: _____
Monthly self breast exam: ❑ Yes ❑ No
Flushing/menopause: ❑ Yes ❑ No

Sexually active	❑ Yes	❑ No
Practice safe sex	❑ Yes	❑ No
Pain/Bleeding after sex	❑ Yes	❑ No
Pregnant	❑ Yes	❑ No
Planning Pregnancy	❑ Yes	❑ No

Number of Pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Birth control method: _____
Name of birth control if using: _____

OTHER DOCTORS

Please list all of the other doctors that you are currently seeing.

Name / Specialty	Reason

SIGNATURE

Signature of person completing form _____ date _____

Relationship: _____ (if other than patient)

This section to be completed by Provider
To be reviewed every three (3) years or as health status changes.

Date Reviewed: _____ Provider Initials: _____ Date Reviewed: _____ Provider Initials: _____

Date Reviewed: _____ Provider initials: _____ Date Reviewed: _____ Provider Initials: _____

Family Medicine Specialists P.C.

William C. Adcox, M.D., F.A.A.F.P.
Diplomate, American Board of Family Practice
Natashia L. Conley, M.D.
Board Certified Family Physician

Prescription Policies

1. I agree to allow **24 hours** for prescription refills.
2. I understand that prescription refill requests after 4:00pm will not be received until the next business day.
3. I understand that a follow-up visit may be required in order to obtain a refill.
4. I agree to take all medications exactly as instructed. I am **NOT** allowed to change dosage amounts to alter the time schedule of taking medication without first speaking to my physician or his staff.
5. Narcotic medications **WILL NOT** be phoned in after hours or on weekend or holidays.
6. The providers of Family Medicine Specialists **WILL NOT** refill prescriptions that have been lost, stolen, misplaced, or destroyed.
7. I **WILL NOT** give, trade, or sell my medications.
8. The following are conditions for immediate termination from the practice:
   A) Obtaining narcotics from any other physician while under Family Medicine Specialists care without notification.
   B) Altering or forging a prescription. **(This is a felony and will be reported).**
9. I am aware that most manufactures of drugs used to treat chronic pain, or illness recommend against the operation of heavy equipment, which include driving a motor vehicle. Please be aware of the medication warnings and if you choose to operate a vehicle you could be charged with a DUI.
10. I **WILL NOT** combine any medication with the consumption of alcohol.
11. Patients may be terminated from the practice with 30 days notice for noncompliance with a medication.
12. I **MUST** keep all appointments as recommended.
* 13. My provider may choose to provide me with a sample of a prescribed medication; **this is a trial sample only. Samples are not for maintenance purposes.** A prescription will be sent to your pharmacy.
14. Professional mannerism is to be maintained with **ALL** staff members at all times.

I have read, understand, and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe my medications.

Patient Name (Printed): _____ DOB:_____

Patient Signature:_____ Date:_____

Patient Consent Form

I hereby give my consent for **Family Medicine Specialists, P.C.** to use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment** and healthcare **Operations (TPO)**. (The **Family Medicine Specialists Notice of Privacy Practices** provides a more complete description of such uses and disclosures).

I have the right to review the **Notice of Privacy Practices** prior to signing this consent. **Family Medicine Specialists, P.C.** reserves the right to revise its **Notice of Privacy Practices** at any time.

With this consent, **Family Medicine Specialists, P.C.** may call my home or other alternative location to leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO,** such as appointment reminder and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Family Medicine Specialists, P.C. restrict how it uses or discloses my **PHI** to carry out **TPO.** However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Family Medicine Specialists, P.C.** to use and disclose my **PHI** to carry out **TPO.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or late revoke it, Family Medicine Specialists, P.C. may decline to provide treatment to me.

_____ _____/_____/_____
Print Name of Patient Patient Date of Birth

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____
Print Name of Legal Guardian

Acknowledgement of Receipt of Privacy Notice

I understand a copy of the Notice of Privacy Practices of Family Medicine Specialists, P.C is posted in the waiting room for me to review.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the office of Family Medicine Specialists, P.C.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

Health Care Information Director
Family Medicine Specialists, P.C.
100 Genevieve Court, Suite A
Peachtree City, GA 30269
(770)486-1818

_____ _____/_____/_____
Print Name of Patient Patient Date of Birth

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____
Print Name of Legal Guardian

Guarantee of Payment for Services & Assignment of Benefits

It is the policy of Family Medicine Specialists P.C. that you must pay for services when rendered.

As a courtesy, Family Medicine Specialists P.C. will file primary insurance claims only, unless the primary insurance is Medicare. If this applies to you, we will file to your secondary insurance.

In the event that any of the above named companies or individuals fail to make prompt payment, I hereby give my personal guarantee of payment for all charges herein occurred. If this account is placed with an attorney and/or collection agency for collection, the undersigned parties agree to pay all reasonable attorney fees and costs of collection.

I hereby authorize insurance benefits to be paid directly to Family Medicine Specialist P.C., and I am financially responsible for non-covered services. I also authorize Family Medicine Specialists P.C. to release any information in the processing of this claim.

I hereby attest that I have read fully and understand fully the statements, guarantee of payment an assignment of benefits outlined above.

PLEASE NOTE:
OUR OFFICE MUST HAVE A COPY OF YOUR CURRENT INSURANCE CARD OR YOU WILL BE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. ENROLLMENT FORMS WILL NOT BE ACCEPTED. WE WILL NOT BE ABLE TO CALL FOR INSURANCE VERIFICATION AT THE TIME OF YOUR VISIT.

Insurance and Coverage and Referral Waiver

I understand that my eligibility for coverage has not been verified at the time of my appointment, but I want to receive medical services from Family Medicine Specialists, PC.

I am aware that when the insurance is finally verified, there is a disclaimer, which states that they do not guarantee payment, even though I may be eligible for benefits at the time of service. I further understand that it is not the responsibility of Family Medicine Specialists, PC to know what my plan benefits are. If it is determined that I am not eligible for coverage or that the medical services are not covered, I understand that I will be responsible for payment for all services provided.

Referrals

I understand that if an insurance referral from Family Medicine Specialists, PC is needed; the request has to been made at least forty-eight (48) hours before my appointment date. If a request is not made at least **forty-eight (48)** hours before my appointment, I understand that I may be responsible for all services rendered on the day of the visit.

_____ _____/_____/_____
Signature of Patient/Legal Guardian Date

_____ _____/_____/_____
Print Patient Name Patient Date of Birth