Internal Medicine Associates of Lawrence County PATIENT REGISTRATION

Name_____ SS#_____

Street Address_____ Date of birth_____ Marital status: S M W

City_____ State_____ Zip_____

Telephone: Home_____ Cell_____ Referred by_____

PATIENT EMPLOYER INFORMATION

Employer name_____ Tel#_____

Employer street address_____ City / State_____ Zip_____

SPOUSE'S INFORMATION (IF RELEVANT)

Name_____ SS#_____

Spouse's Date of Birth_____ Spouse's employer / address_____

EMERGENCY CONTACT (Family, Friend, Employer)

Name_____ Relationship_____ Tel#_____

Address_____ City / State_____ Zip_____

INSURED PERSON (IF NOT PATIENT)

Name_____ Tel#_____

Street Address_____ City / State_____ Zip_____

Relationship to patient_____ Date of Birth_____ SS#_____

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with **payment and health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As states in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Office.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this **Consent Form** after you have signed it.

Date_____ Signature_____

ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorize direct payment of medical/surgical benefits to Internal Medicine Associates of Lawrence County for services rendered by us in person or under our supervision. I request that payment from my insurance company be made directly to Internal Medicine Associates of Lawrence County. I understand that I am financially responsible for any balance not covered by my insurance and also for the payment of any claims denied by them. I permit a copy of this authorization to be used in place of the original.

Date_____ Signature_____

(Patient, if patient is under 18 years old signature of parent or guardian)

PATIENT HISTORY FORM

PATIENTS NAME _____ DATE _____

DATE OF BIRTH _____ PATIENTS SEX _____

ALLERGIES TO MEDICATIONS, X-RAY, DYES OR OTHER SUBSTANCES

If yes, please list name of medicine and type of reations:

PRESENT MEDICATIONS (prescription, over-the-counter, vitamins, herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE

PAST MEDICAL HISTORY

Have you had problems with or are presently complaining of any of the following (check all that apply)

- ☐ High blood pressure
- ☐ Chest pain / tightness
- ☐ Shortness of breath
- ☐ Dizzy spells
- ☐ Palpitations
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Asthma
- ☐ Abdominal discomfort
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Unexplained weight loss/gain
- ☐ Kidney disease
- ☐ Frequent/difficult urination
- ☐ Arthritis
- ☐ Low back problems
- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Other (please specify): _____

LIST AND SUPPLY DATES OF:

Year last received if known:

Tetanus	_____	Hepatitis B	_____	Pap Smear	_____	Cholesterol Check	_____
Typhoid	_____	Pneumonia	_____	Mammogram	_____	Stool Check for blood	_____
Polio	_____	Flu	_____	Breast Exam	_____	Rectal / Prostate exam	_____
Rubella	_____			Colonoscopy	_____		

Surgeries: _____

FAMILY HISTORY

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

ILLNESS	FAMILY MEMBER	Approx. age when diagnosed
Cancer (describe type)		
High blood pressure		
Heart attack		
Diabetes		
Stroke		
Mental disease (anxiety, depression, etc)		
Other (please describe)		

PREVENTION

Do you wear seatbelts?	☐ No	☐ Yes	If no, why not? _____
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you use drug? (marijuana, cocaine, crack, etc)	☐ No	☐ Yes	If yes, explain: _____
Do you have a "living will"?	☐ No	☐ Yes	
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Are you in a relationship in which you have been physically hurt by your partner?	☐ No	☐ Yes	

Method of birth control: _____