_______________ / / _______________ / /

Patient Name | Date of Birth | Social Security Number | Date

Patient Registration Form

Patient Address ______________________________

City | State | Zip Code

Home Phone ______________________________

Cell Phone ______________________________

Email Address ______________________________

Sex ☐ Male ☐ Female

Is patient full time student?

☐ Yes ☐ No

Ethnic Background *(for Medical Purposes-Optional)*

☐ African American ☐ White

☐ Asian

☐ Hispanic ☐ Other ______________

Marital Status

☐ Single ☐ Married

☐ Separated ☐ Divorced

☐ Widowed

Who referred you to our practice? ______________________________

Employer Information

Employer ______________________________

Occupation

☐ Full Time ☐ Part Time

Address ______________________________

Phone Number ______________________________

***Please complete for the person responsible for the bills (if other than patient)*

*** Required for patients under 18*

Emergency Contact

Name ______________________________

Address ______________________________

____

Phone Number ______________________________

Address ______________________________

Home Phone ______________________________

Work Phone ______________________________

Cell Phone ______________________________

Relationship ______________________________
(to Patient)

Guarantor Information**

Last Name ______________________________

First Name ______________________________

Address ______________________________

____

Social Security# ______________________________

Date of Birth ______________________________

Relationship ______________________________
(to Patient)

Patient Registration Form

______________________ / / ______________________ / /

Patient Name   Date of Birth   Social Security Number   Date

Primary Insurance Information

Insurance Company Name ______________________

Patient Address ______________________

____

Name of Insured Mr. Mrs. Ms. ______________________

D of B Month _____ Day _____ Year _____   Policy # ______________________

Co-Pay *(If Applicable)* ______________________   Group # ______________________

Relationship ______________________   Effective Date ______________________

Secondary Insurance Information

*** Important- Do you have any other Medical Insurance?*

Insurance Company Name ______________________

Patient Address ______________________

____

Name of Insured Mr. Mrs. Ms. ______________________

D-of-B Month _____ Day _____ Year _____   Policy # ______________________

Co-Pay *(If Applicable)* ______________________   Group # ______________________

Relationship ______________________   Effective Date ______________________

Miscellaneous

Is this visit related to an accident?

☐ Date of Accident ______________________

☐ Auto ☐ Work ☐ Other ______________________

For Official Use Only

______________________   ______________________

Enrollment Verification By: Co-Pay Amount:

Patient Registration Form

_____________________ / / _____________________ / /

Patient Name | Date of Birth | Social Security Number | Date

Authorization for Treatment and Financial Responsibility

I *(or designated guardian)* authorize the physician to provide treatment and to release medical information to my insurance as may be necessary for payment of physician claims.

I*(or designated guardian)* Hereby authorize payment directly to the physician of the benefits otherwise payable to me but not to exceed regular charges for physician claims. I *(or designated guardian)* understand that I am financially responsible to the Physician for charges not covered by my insurance.

Parent/Guardian Signature ______________________ Date ______________

Authorization for Release of Information

I authorize my Physician to supple another Physician involuted in my medical care with copy of necessary medical records and/or test results requested by the Physician but ordered by my Primary care Physician. I understand this is for the release of medical information only. If I am a managed care subscriber. I authorize my Physician to allow my Managed Care Organization access to my chart for Quality Review purposes

Parent/Guardian Signature ______________________ Date ______________

Medicare Patients

Patient's certification, authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct, I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries / carriers and information needed for Physicians claims and other related medical claims. I request that payment of claims be made on my behalf for authorized benefits under my health insurance. I hereby authorize payment directly to my Physician for Insurance benefits otherwise payable to me. Payments are not to exceed the balance due of the practice's regular charges for those claims. I understand that my physician will bill HCFA using the form "signature on file"and i'm aware that my signature as written below constitutes the "on file" signature.

Parent/Guardian Signature ______________________ Date ______________

Medigap Benefits

I hereby give my Physician permission to ask for Medigap payments for my medical care. I understand that my Medigap insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to my Medigap insurer. I request that payment of authorized Medigap benefits be made to PHCS Physician Services on my behalf for any services furnished me by my Physician. I authorize any holder of medical information about me to release to my Medigap Insurer any information needed to determine these benefits or the benefits payable for related service.

Parent/Guardian Signature ______________________ Date ______________

Consent of Treatment for Minor / Incapacitated Patients

I hereby authorize the Physician to provide medical treatment to: ______________________

Patient is unable to consent to medical treatment because minor child or: ______________________

______________ ______________ ______________ / /

Signature Guardian | Name of Guardian | Witness Signature | Date

Patient Registration Form

______________ / / ______________ / /

Patient Name Date of Birth Social Security Number Date

Past Medical History Information

Current Occupation ______________

(Please circle if you have any of the following)

Diabetes	Lower Back Pain	Colitis	Depression	Asthma
Pneumonia	Arthritis	Ulcers	Hepatitis	Kidney Stones
Skin Disease	Gall Bladder Disease	Stomach Disorders	Bronchitis	High Blood Pressure
Heart Disease	Thyroid Disease	Tuberculosis	Blood Disorders	Head & Neck Radiation Treatment
Venereal Disease	Hay Fever	Kidney Disease	Anxiety	

Operations & Hospitalization

Operations: *(Please list and supply the dates of) (Please list and supply the dates of)*

☐ Gall Bladder / / ☐ Appendix / / ☐ Hysterectomy / /

☐ Other ______________ / /

Hospitalization: *(Other than for surgery)*

☐ ______________

Medication: *(Prescription, over-the-counter, vitamins, herbs, est)*

Drug Name	Dose	Drug Name	Dose

Diet: *(Please list any special diet)*

____

Allergies

____

Immunization History *(Have you had)*

☐ Hepatitis B Yes/No When / /

☐ Pneumonia Shot Yes/No When / /

☐ Flu Shot Yes/No When / /

☐ Tetanus Yes/No When / /

☐ Other ______________ Yes/No When / /

Family History *(Has any member of your family parents,grandparent, siblings ever had the following?*

	Which Member of family	*Age Diagnosed*
Cancer *(type)*		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental Health anxiety/depression		

	√Which Member of family	*Age Diagnosed*
Drug / Alcohol depression		
Glaucoma		
Bleeding Disease		
Other		

Patient Registration Form

____________ / / ____________ / /

Patient Name | Date of Birth | Social Security Number | Date

Preventive Care *(When was the last)*

Women:

Pap Smear ________ Breast Exam ________ Stool Check Blood ________

Mammogram ________ GYN Exam ________ Cholesterol Check ________

Method of Birth Control ________

Name of GYN ________

Men

Cholesterol Check ________ Prostate Exam ________

- ☐ Yes ☐ No Do you Smoke? *If Yes how many Packs per day* ________
- ☐ Yes ☐ No Do you drink alcoholic? *If Yes how much per week* ________
- ☐ Yes ☐ No Do you drink coffee or tea? *If Yes how many cups per day* ________
- ☐ Yes ☐ No Do you use Illegal drugs? *If Yes how explain* ________
- ☐ Yes ☐ No Have you ever had a blood transfusion? *If so when* ________
- ☐ Yes ☐ No Have you engaged in any activity which has put you at risk for HIV/AIDS? *If yes explain* ________
- ☐ Yes ☐ No Do you wish to be tested for HIV/AIDS?
- ☐ Yes ☐ No Have you ever worked with chemical paints asbestos, or other hazardous material? *If yes explain* ________
- ☐ Yes ☐ No Do you feel afraid of your significant other?
- ☐ Yes ☐ No Do you wear seatbelts?
- ☐ Yes ☐ No Do you wear a bike helmet? ______ N/A
- ☐ Yes ☐ No Do you visit the dentist on a regular basis?
- ☐ Yes ☐ No If there is a gun in your home, is it locked and kept separately from the ammunition? ______ N/A
- ☐ Yes ☐ No Do you have a Living Will? *If so please provide us a copy for your chart*
- ☐ Yes ☐ No Do you have power of attorney for health care decision making
- ☐ Yes ☐ No Do you want information on "Living Wills"?
- ☐ Yes ☐ No Do you have an organ donor card?
- ☐ Yes ☐ No Do you have smoke detectors on each floor of your home?
- ☐ Yes ☐ No If yes, do you regularly check the batteries?
- ☐ Yes ☐ No Are you on a special diet?

____________ / /

Patient Signature | Date

____________ ____________ / /

Complete by signature | Relationship to Patient | Date

____________ / /

Reviewed By | Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Family Practice Center of Newtown
638 Newtown Yardley Road
Commons West, Suite 2E
Newtown, Pennsylvania 18940
215. 968. 1616

ACKNOWLEDGEMENT FORM

I have reviewed the **Notice of Privacy Practices**
and I have been provided an opportunity to review it.

Name	Birth Date
Signature	Date

INDIVIDUAL PATIENT'S AUTHORIZATION

Family Practice Center of Newtown
638 Newtown Yardley Road
Commons West, Suite 2E
Newtown, Pennsylvania 18940
215. 968. 1616

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE
YOUR PROTECTED HEALTH INFORMATION FOR A SPECIFIC PURPOSE

Name ____

Address ____

City______________________________ State ______________ Zip ________

Phone ____

E-mail Address ____

The Use and Disclosure Authorized

Psychotherapy Notes________Check here if this authorization is for psychotherapy notes.

Name of person or persons you are authorizing to (use or to disclose to) your protected health info.

____

____

Name of person or persons you are authorizing to (use or to disclose to) your protected health info.

____

____

Family Practice Center of Newtown

Ending This Authorization

Select one of the two following choices:

☐ This authorization will end on the following date ______________________________

☐ This Authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use or disclosure.

Changing Your Mind About This Authorization

I understand that I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTICE TO THE Privacy Office at your office. However, I understand that I may not revoke any prior authorizations that have taken place before my written notice.

Signing This Authorization is *Not A Condition of Treatment*

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.However, I understand that signing an authorization that permits the use and or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also I may be required to sign an authorization if my treatment is provided solely for the pmpose of creating protected health information for disclosure to a third party. And under some circmnstances, a health plan may condition my emrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

Possibility of Redisclosure

Federal privacy rules may not protect the privacy of my health information one the recipient redisciöses my health information.`

Individual Patients Signature

I.understand that by signing this form I am confirming the use and or disclosure of my health information:

Signature ______________________________ Date ______________

Personal Representative Name ______________________________

Signature/relationship ______________________________

Family Practice Center of Newtown, PC

Catherine Spratt Turner, D. 0.
Valerie· Castano, CRNP
638 Newtown Yardley Road, Suite 2E
Newtown, Pennsylvania 18940

February 18, 2014

Dear Patient,

In an effort to contain rising healthcare costs for both the patients and the doctor's offices, we are trying to be proactive with your deductible and co-insurance costs.

We are asking for a credit card to keep on file so that any deductible or insurance costs will be covered in a timely manner thus saving you time and saving us the cost of the billing process.

AT NO TIME WILL WE CHARGE ANYTHING TO THIS CARD IF YOU ACCOUNT REMAINS AT A ZERO BALANCE. ALSO NO CHARGES WILL BE MADE WITHOUT FIRST NOTIFYING YOU OF THE IMPENDING CHARGE.

We thank you in advance for your cooperation.

Family Practice Center of Newtown, PC.

Patient Name ______________________________

Card# ______________________________

Exp Date ______________________________

CVV # ______________________________

☐ Visa ☐ Mastercard ☐ AmExp ☐ Discover ☐ Debit ☐ Credit