PatientRegistrationForm

Date:______________________________

Primary Care Physician:______________________________

Patient's Information

Please present your photo identification, health insurance card(s), prescription card, and your social security card to the front desk.

Patient's Full Name:______________________________ **DOB:**______________________________

Is this your legal name? Yes No **If no, what is your legal name?**______________________________

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

Primary Language:______________________________ **Race:**______________________________

SSN:______________________________ **Email:**______________________________

Cell Phone:______________________________ **Home Phone:**______________________________

Address:______________________________ **Pharmacy:**______________________________

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Employer:______________________________ **Phone:**______________________________

Primary Insurance:______________________________ **Member ID:**______________________________

Subscriber Name:______________________________ **DOB:**______________________________

Secondary Insurance:______________________________ **Member ID:**______________________________

Subscriber Name:______________________________ **DOB:**______________________________

Would you like to list anyone as an emergency contact? If yes, please provide their information below.

Name:______________________________ **Phone:**______________________________

Parent/Guarantor/Responsible Party Information (if applicable)

The Guarantor formally accepts responsibility for payment's on patient's account and charges not covered by insurance company.
Signature and photo identification from the person listed as Guarantor of this account is REQUIRED.

Mother's Name:______________________________ **DOB:**______________________________

SSN:______________________________ **Email:**______________________________

Cell Phone:______________________________ **Home Phone:**______________________________

Address:______________________________

____

Employer:______________________________ **Phone:**______________________________

Father's Name:______________________________ **DOB:**______________________________

SSN:______________________________ **Email:**______________________________

Cell Phone:______________________________ **Home Phone:**______________________________

Address:______________________________

____

Employer:______________________________ **Phone:**______________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Connelley Family Medical PLLC. I understand that I am financially responsible for any balance left unpaid by my insurance company. I also authorize CFM to authorize any protected health information to my insurance company if it is required to process my claims.

Guarantor Signature:______________________________

Date:______________________________

Spouse Information (*if applicable*)

Name:______________________ **DOB:**______________________

SSN:______________________ **Email:**______________________

Cell Phone:______________________ **Home Phone:**______________________

Address:______________________

____

Employer:______________________ **Phone:**______________________

May we contact your spouse if we are unable to reach you? Yes No

Protected Health Information Authorization

The following individuals **MAY BE TOLD** about my illness and/or treatment(s): (*If a minor, please list* ***ALL*** *other individuals who may bring your child to their visits. If that person is not listed, the person* ***WILL NOT*** *be allowed to bring your minor to their visits.)*

Name:______________________ **Relationship:**______________________

Name:______________________ **Relationship:**______________________

Name:______________________ **Relationship:**______________________

Please **DO NOT SHARE** my protected health information with the following:

Name:______________________ **Relationship:**______________________

Name:______________________ **Relationship:**______________________

Name:______________________ **Relationship:**______________________

The above information is true to the best of my knowledge. I understand that it is my responsibility to update any and all information for the patient listed on this form. I authorize CFM to contact me via all means necessary. I understand that any time that I am non-compliant with medical care advised by my healthcare provider at CFM or if I post anything derogatory about CFM, its providers or staff, on any social media platform that I may be dismissed as a patient. By signing below, I, the undersigned patient or authorized representative of the patient, consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures ordered by this office or its healthcare providers. I agree that regardless of my insurance status, that I am ultimately responsible for the balance of my account. I understand that the insurance that I provide will be billed as a courtesy. I authorize that my insurance benefits be paid directly to the physician or this office. All deductibles, co-payments, and co-insurances are due at the time the service(s) are rendered. I understand that I am financially responsible for any balance left unpaid by my insurance company for any reason, including but not limited to PCP issues, Maximum Benefits reached, co-pays, deductibles, co-insurances, out-of-network charges, non-covered charges and diagnoses, or any update that my insurance company has requested but not received by me. I authorize Connelley Family Medical PLLC to release my protected health information if it is required by my insurance company to process my claims. I understand that after three (3) consecutive billing statements without a monthly payment, can and will result in my account being referred to an outside collection agency without notice.

By signing below, I have read and agree to ***ALL*** *terms and conditions listed above.*

Patient Name:______________________

Guarantor Signature:______________________

Date:______________________

Patient Health History Form

Patient Name: ______________________________ **D.O.B.:** ________________

Allergies: *Please list all allergies that you have:* ______________________________

Previous Surgeries: *Please list past surgeries with approximate date:*

____

____

Serious Injuries: *Please describe any serious injuries you have had and the treatment you received for the injury.*

____

____

Do you drink alcohol? ☐ Yes ☐ No *If yes, how much per week?* ______________________________

Do you smoke? ☐ Yes ☐ No *If yes, how many cigarettes per day?* ______________________________

Do you consume caffeine? ☐ Yes ☐ No *If yes, how much per day?* ______________________________

Are you on a special diet? ☐ Yes ☐ No *If yes, please describe.* ______________________________

Please check ✓ any of the following diagnoses that may apply to you.

☐ Anemia
☐ Anxiety
☐ Heart Disease
☐ Kidney Disease
☐ COPD
☐ Dementia
☐ Gout
☐ Cholesterol Problems
☐ High Blood Pressure
☐ Thyroid Problems
☐ Heart Disease
☐ Cancer, Type(s): ______________________________

☐ Depression
☐ Chronic Pain
☐ Alzheimer's Disease
☐ Asthma
☐ Atrial Fibrillation
☐ History of Heart Attack
☐ Type I Diabetes
☐ Type II Diabetes
☐ GERD
☐ Heart Failure
☐ Migraines

☐ Insomnia
☐ Sleep Apnea
☐ Vitamin Deficiency
☐ Emphysema
☐ Glaucoma
☐ Lupus
☐ Arthritis
☐ History of Stroke
☐ Fibromyalgia
☐ Restless Leg Syndrome
☐ ADD or ADHD

☐ Other, please specify: ______________________________

If you visit any other physicians' offices, please list them below.

____

____

Medications: Please list all medications you are taking with dosage and frequency. If more space is required, turn page over and continue listing on the back of this page.

MEDICATION NAME	DOSAGE/FREQUENCY

Family History: Do you know of any blood relative who has or had: (Check ✓ all that apply)

☐ Asthma	☐ Aneurysm	☐ Brain Tumor	☐ Cancer, Type: ______
☐ Type I Diabetes	☐ Type II Diabetes	☐ Epilepsy/Seizures	☐ Headaches/Migraines
☐ High Blood Pressure	☐ Kidney Disease	☐ Lung Disease	☐ Multiple Sclerosis
☐ Psychiatric Disease(s)	☐ Stroke	☐ Thyroid	☐ Heart Attack
☐ Other: ______________________________			