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287 FAMILY MEDICINE
972-346-8115

Patient Registration Information

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date: _____ Last Name: _____ First Name: _____ MI: _____

SSN: _____ Birth-date: _____ Age: _____ Gender: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status:_____

Sexual Orientation:_____ Employer: _____

Employer's Address: _____

Emergency Contact: _____ Home Phone: _____

Cell Phone: _____ Relationship to you:_____

Insurance Information:

Name of Primary ***Medical*** Insurance: _____

Primary Cardholder's Name: _____ Date of Birth: _____

Primary Cardholder Address: _____

Relationship to you: _____

Name of Secondary ***Medical*** Insurance (if applicable): _____

Secondary Cardholder's Name: _____ Date of Birth: _____

Secondary Cardholder Address: _____

Relationship to you: _____

New Patient History Form

Patient's Name: _____ DOB: _____ Date: _____

Briefly describe what problem brings you to the office today: _____

_____

_____

Previous Primary care doctor: _____

Any major specialists you currently see:

_____

_____

List all of your medications with ALL dosages, frequency and any over-the-counter medications

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medication allergies and their reaction

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Medical problems (circle)

Heart failure, Diabetes Type_____, Hypo/Hyper Thyroid, Seizures, TB, Cancer _____, depression, anxiety, OCD, high blood pressure, high cholesterol, kidney stones, bleeding problems, heart disease, kidney disease, urine infections, arthritis, asthma or COPD, PCOS, skin problems, ADHD _____

Additional Info: _____

_____

_____

Implanted Devices: _____

Social History

Current occupation:_____

Do you drink alcohol? YES NO If YES: OCCASIONAL 1/DAY 2-3/DAY 4+/DAY

Do you use illegal drugs? YES NO IF YES: _____

Do you smoke? YES NO If YES, # years_____ OCCASIONAL 1/2pack/day 1 pack/day 1+ pack/day

IF QUIT SMOKING WHEN and HOW MANY YEARS DID YOU SMOKE: _____

Family medical history				**Disease or cause of death**
1. Father	Age _____	☐ Living	☐ Deceased	_____
2. Mother	Age _____	☐ Living	☐ Deceased	_____
3. Brother	Age _____	☐ Living	☐ Deceased	_____
4. Brother	Age _____	☐ Living	☐ Deceased	_____
5. Sister	Age _____	☐ Living	☐ Deceased	_____
6. Sister	Age _____	☐ Living	☐ Deceased	_____

Past surgeries and the dates

1. _____
2. _____
3. _____
4. _____
5. _____

Prior Test/Exams

Eye Exam ☐ Yes ☐ No IF YES, date and Dr. Office:_____

PAP smear(female) ☐ Yes ☐ No IF YES, date and Dr. Office:_____

Mammogram(female) ☐ Yes ☐ No IF YES, date and Dr. Office:_____

Last menstrual cycle(female) ☐ Yes ☐ No IF YES, date:_____

Bone Density Study ☐ Yes ☐ No IF YES, date and Dr. Office:_____

Cardiac Work-Up ☐ Yes ☐ No IF YES, date and Dr. Office:_____

EKG ☐ Yes ☐ No IF YES, date and Dr. Office:_____

Colonoscopy ☐ Yes ☐ No IF Yes, date and Dr. Office:_____

Sleep Study ☐ Yes ☐ No IF YES, date and Dr. Office:_____

Flu shot _____ Last Tetanus _____ Pneumonia shot _____

PSA(male) ☐ Yes ☐ No IF Yes, date and Dr. Office:_____

Review of symptoms

Do you now or have you recently had problems with any of the following? Please circle any that apply

G/U System:	Pain or burning with urination	Kidney stone	Frequency	Slow or small stream	Blood in the urine
	Getting up at night to urinate	Leaking of urine	Urgency	Poor bladder emptying	Recurrent urine
	Abnormal vaginal bleeding	Seasonal problems		Menstrual problems	
General:	Change in weight	Fever			
Skin:	Lumps or Nodules	Breast Lump	Rashes	Sores	Other skin problems
Eyes:	Glaucoma	Cataracts	Glasses	Other eye problems	
ENT:	Trouble swallowing	Earaches	Nose bleeds	Dentures	Sinus problems
Heme/Lymph:	Swollen nodes or glands	Anemia	Bleeding problems		Other blood disorders
C/V:	Irregular heart beat	Heart failure	Phlebitis	Heart valve problem	Heart murmur
	Pain in legs with exertion	Chest pain	Blood clots	Swelling in legs	
	Other heart/blood vessel problems				
Respiratory:	Shortness of breath	Wheezing	Cough	Asthma	Other lung problems
G/I:	Gall bladder problems	Blood in stool	Dark tarry stool	Intestinal bleeding	Diarrhea
	Poor appetite	Hiatal hernia	Ulcer	Indigestion	Hemorrhoids
	Constipation	Vomiting	Nausea	Hernia	
Neuro:	Loss of consciousness	Headaches	Strokes	Dizziness	Paralysis
	Numbness	Weakness			
Psych:	Depression	Anxiety	Other psychological problems		
Musculoskeletal:	Joint replacement surgery	Broken bones	Gout	Arthritis	Bone or joint pain
Endocrine:	Heat or cold tolerance	Hot flashes	Flushing	Skin pigmentation changes	Abnormally thirsty

Do you have any other problems that you would like to discuss with the provider? ☐ Yes ☐ No

Consent for Treatment

I voluntarily consent to medical treatment by Dr. Wilfred Miller / 287 FamilyMedicine and other personnel. I consent to the testing for infectious diseases and testing for drugs if deemed advisable by my provider. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read or have had read to me this consent and understand and agree to its contents.

_____ _____

Patient Signature (or Legal Guardian) Date

Authorization for Release of Information

I, _____, do hereby authorize a representative from 287 Family Medicine to speak with the following person(s) regarding my health care. Please note that without your authorization, we are not allowed by law, in most circumstances, to discuss any information about your health care.

Name	Phone Number	Medical Care	Appointments	Account
_____		☐	☐	☐
_____		☐	☐	☐
_____		☐	☐	☐
_____		☐	☐	☐
_____		☐	☐	☐

_____ _____

Patient Signature (or Legal Guardian) Date

Authorization for Release of Information and Assignment of Insurance Benefits

My provider is authorized to release medical information required in the processing of applications or submissions of information for financial coverage, including information referring to psychiatric care, drug and alcohol abuse, sexual assault or tests of infectious diseases for services provided during this admission. I also agree to the release of medical or other information about me to government regulatory agencies (federal and state) as required by law. For Medicare beneficiaries – I have provided all necessary information for proper assignment of Medicare benefits.

_____ _____

Patient Signature (or Legal Guardian) Date

Agreement of Financial Responsibility

Dr. Wilfred Miller / 287 Family Medicine has established the following financial policies to ensure that patients are informed of our financial policies:

1) Payment is expected at the time of your visit. We will accept cash, credit and debit cards only as forms of payment.
2) Payment will include any unmet deductible, co-insurance, co-pay amount or non-covered charge. If you disagree with your insurance company, it is your responsibility to contact them.
3) We are participating providers for many insurance companies. We will file your insurance. Please remember that insurance is a contract between the patient and the insurance company and ultimately you are responsible for payment in full.
4) If you have an unusually large balance with our office, we will work with you to establish a payment plan. However, it is your responsibility to honor your agreement.
5) All payments will be applied to the oldest charges first except for insurance payments which are applied to the corresponding charges.
6) Disability forms, special insurance forms, extra transcription, copies of medical records, etc. requires office staff time and time away from patient care. We will require pre-payment for these forms and records determined by the length and complexity of the form.
7) After reasonable collection efforts by our staff, we will turn accounts over to a collection agency. When that occurs, you may be discharged as a patient from our practice. You should discuss your difficulties in paying with our staff and make arrangements before it gets to the stage of collection.

Thank you for compliance and cooperation with our financial policies.

I have read and understand the financial policies of 287 Family Medicine. By my signature I agree to the terms outlined in the financial policies.

_____ _____

Patient Signature (or Legal Guardian) Date

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or health care operations.
2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3) The practice reserves the right to change the notice of privacy practices.
4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

_____ _____

Patient Signature Date

_____

Patient Name

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Patient Cancellation Policy

We take great pride in the TIME and SERVICE we provide to our patients. We take your time very seriously and are committed to serving you with the highest level of respect, integrity and in the most cost-effective manner.

While some patient cancellations are inevitable, cancellations with less than 24-hours notice or missed appointments (no-shows) are a great expense to our organization.

We have the following cancellation policy:

- There will be a **$45.00** charge for each cancellation/no-show without a 24-hour notice. This charge will be your responsibility and will not be billed to your insurance company. This charge MUST be paid in full at your next visit.
- **After 2 cancellations/no-shows**, we will notify you and you will be reminded of this policy.
- **After 3 cancellations/no-shows,** we reserve the right to terminate our relationship with you.

Patient to complete and sign:

I have read and understand the above Cancellation Policy. As an active patient of **Dr. Wilfred Miller DO PA / 287 Family Medicine**, I will adhere to this policy and will be financially responsible for any fees incurred as a result of this policy.

_____ _____

Patient Signature Date

_____

Patient Name