FamilyCare Medical Group, P.C.
Patient Registration Form
Please Print ***Date***_____

Name:_____ Sex___F ____M SS#_____
Address:_____City_____Zip_____
Phone_____ Cell Phone_____ Age_____ DOB _____
Marital Status: Single_____ Married____ Divorced/Separated_____ Widow/Widower_____
Patients Employer_____ Occupation_____
Employers Address_____Work Phone_____
Emergency Contact_____ Phone _____
Spouse/Significant Others Name_____Mother's Maiden Name_____
Spouse/Significant Others DOB:_____ SS#_____
Spouse's/Significant Others Employer _____ Occupation_____
Employers Address _____Work Phone_____
Pharmacy Name & Address_____ Pharmacy Phone #_____
Language Preference_____ Race_____ Email _____
Ethnicity Non-Hispanic/Spanish Origin ____ Spanish/Hispanic Origin_____ Patient Declined/Unknown_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Subscriber Name:_____ ID#:_____
SS#:_____ DOB:_____
Secondary Insurance Company.:_____
Subscriber Name:_____ ID#:_____

HIPAA DOCUMENTATION

Office Policy-Mailings on Reminder of Appts. And Office Policy-Mailings on Results
(Please answer all questions below and then sign and date)

1 I acknowledge that I have been given the opportunity to read and/or receive a copy of Family Care Medical Group's Privacy Notice. YES NO

2.

Leave appointment message on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

Leave Medical information on:	**YES**	**NO**
Home Phone (including autocall)?		
Mobile Phone (including autocall)?		
Mobile Text (including autocall)?		
Work Phone?		
With another person? List name(s) below		
Send via Mail?		
Send via Email?		

3. Person(s) authorized to Discuss Your Personal Medical Information.

Contact Name	Relationship	Phone	Cell Phone

Signature_____ Date_____

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_____ Date_____

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_____ Date_____

12/03, 1/05, 5/05, 1/13, 5/13

FamilyCare Medical Group

Meghan Doran, FNP-C, DCNP
436 Hinsdale Road Camillus, NY 13031
Phone # (315) 488-0996

Name: _____ Date of Birth: _____

Please circle any problems that apply to you:

Yes Allergies
Yes Anemia
Yes Anxiety
Yes Arthritis
Yes Cancer-Please State Type _____
Yes Coronary Heart Disease
Yes COPD
Yes Cholesterol problems
Yes High Blood Pressure
Yes Diabetes
Yes HIV/AIDS
Yes Thyroid Disease
Yes Tuberculosis
Yes Kidney Disease
Yes Glaucoma
Other: _____

Yes Appendix Removal
Yes Brain Surgery
Yes Cardiac Bypass
Yes Colon Surgery
Yes Ear Surgery
Yes Gallbladder Surgery
Yes Weight Loss Surgery
Yes Hernia Repair
Yes Hysterectomy
Yes Prostate Surgery
Yes Small Intestine Surgery
Yes Tonsillectomy/Adenoidectomy
Yes Vasectomy
Yes Fracture Surgery
Yes Vascular Surgery
Other: _____

Please list prescribed and over the counter medications that you are currently taking:

_____
_____
_____

Allergies to Medications?

_____
_____

Your Occupation? _____ ***Indication Marital Status:*** _____ ***Whom do you reside with:*** _____

Please circle and answer each question that may apply to you:

Yes No Alcohol Use
Yes No Smoking, if yes, packs per day ___ years of smoking ____ quite date _____
Yes No Do you use sunscreen on a daily basis
Yes No Caffeine intake, if yes, how much per day _____

Please indicate family history of skin cancer below:

Mother Yes No If yes, what type _____

Father Yes No If yes, what type _____

Sister Yes No If yes, what type _____

Brother Yes No If yes, what type _____

Were you referred by a Physician, if yes, whom: _____

Signature: _____ **Today's Date:** _____

PLEASE FILL OUT ONLY, IF YOU'VE SEEN A DERMATOLOGIST BEFORE

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Meghan Doran, FNP-C, DCNP 436 Hinsdale Rd, Camillus, NY 13031 (P) 315-488-0996 (F)315-234-3676

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**