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

Patient Personal History Form

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Hospitalization/Surgeries (Reason/Daignosis/Procedure) Date

1
2
3
4
5

Current Medical Probems/Diagnosis

1
2
3
4
5
6

Family Medical History (Parent(s)/Sibling(s)/Aunt(s)/Uncle(s)/Grandparent(s)

1
2
3
4
5

All Current Medications (Include prescriptions, non-prescription, vitamin & supplements)

Name	*Dosage*	*How Often?*

(Please list any additional on the back of this page)

Protocol for Fasting Appointments

If you have a morning fasting appointment, you may have black coffee, plain tea and water in the morning of your appointment. You may take you medications as normal, unless they require you to take them with food.

If you have an afternoon fasting appointment, you may have something light to eat 4 hours prior to your appointment.
(Examples: lightly buttered toast, oatmeal, non-sugar cereal, etc.) You are allowed to have black coffee, plain tea and water during the day until your appointment time.