

Olympus Family Medicine

Patient Registration Form

TODAY'S DATE _____

PATIENT INFORMATION

DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE SOC SEC #: ____-____-____
MM DD YYYY

FULL NAME: _____ HOME PH #: _____
LAST FIRST MI

ADDRESS: _____ WORK PH #: _____
CELL PH #: _____

CITY STATE ZIP

EMPLOYER / SCHOOL NAME: _____

MARITAL STATUS: S M D W PARENT / PARTNER NAME: _____

EMERGENCY CONTACT: _____ PH #: _____
LAST FIRST MI

PREFERRED PHARMACY (name & location): _____

HOW DID YOU LEARN ABOUT US? _____

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY

INS. PLAN NAME: _____	INS. GROUP # _____
INS. PLAN ADDRESS: _____	INS. ID # _____ (Policy Number)
_____ CITY STATE ZIP	INS. PLAN PH # _____
_____ CITY STATE ZIP	COPAY AMOUNT: _____
PRIMARY INSURED'S NAME: _____	PRIMARY'S DOB: ____/____/____ LAST FIRST MI MM DD YYYY
PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER _____	

SECONDARY INSURANCE POLICY (IF APPLICABLE)

INS. PLAN NAME: _____	INS. GROUP # _____
INS. PLAN ADDRESS: _____	INS. ID # _____ (Policy Number)
_____ CITY STATE ZIP	INS. PLAN PH # _____
_____ CITY STATE ZIP	COPAY AMOUNT: _____
PRIMARY INSURED'S NAME: _____	PRIMARY'S DOB: ____/____/____ LAST FIRST MI MM DD YYYY
PATIENT'S RELATIONSHIP TO PRIMARY: SELF CHILD SPOUSE OTHER _____	

PRESENT HEALTH

Please review and mark **ALL** items that have applied to you **within the last month** (including today)

GENERAL HEALTH:	<input type="checkbox"/> None	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of appetite
	<i>Females:</i>	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> First day of last menstrual period _____	
EYES:	<input type="checkbox"/> None	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Double vision	<input type="checkbox"/> Severe Redness	<input type="checkbox"/> Crusting
EARS:	<input type="checkbox"/> None	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Dizziness
NOSE:	<input type="checkbox"/> None	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus pain/pressure
MOUTH/THROAT:	<input type="checkbox"/> None	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Problems swallowing	<input type="checkbox"/> Sores in mouth	<input type="checkbox"/> Tooth pain <input type="checkbox"/> Hoarseness
CHEST/HEART:	<input type="checkbox"/> None	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Racing/pounding heart	<input type="checkbox"/> Leg pain/limp w/ walking	<input type="checkbox"/> Problems breathing w/ lying down
RESPIRATORY:	<input type="checkbox"/> None	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Coughing up blood or mucus w/ blood
STOMACH:	<input type="checkbox"/> None	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Vomiting up blood
BOWELS:	<input type="checkbox"/> None	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Black/bloody stools	<input type="checkbox"/> Unusual change in stool size/shape/color
URINARY TRACT:	<input type="checkbox"/> None	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Increased urination	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Pain w/ urination <input type="checkbox"/> Waking to urinate ____ # times per night
REPRODUCTIVE:	<input type="checkbox"/> None				
	<i>Females:</i>	<input type="checkbox"/> None	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Breast pain	<input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Pain w/ intercourse
	<i>Males:</i>	<input type="checkbox"/> None	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Penile discharge	<input type="checkbox"/> Lump/swelling in scrotum/testicle(s)
MUSC/SKEL:	<input type="checkbox"/> None	<input type="checkbox"/> Back pain	<input type="checkbox"/> Pain in muscles/joints	<input type="checkbox"/> Limited range of motion in joints	
SKIN:	<input type="checkbox"/> None	<input type="checkbox"/> Rash	<input type="checkbox"/> Redness	<input type="checkbox"/> Sores	<input type="checkbox"/> Changing moles/warts or other lesions
NEUROLOGICAL:	<input type="checkbox"/> None	<input type="checkbox"/> Seizures	<input type="checkbox"/> Problems w/ coordination	<input type="checkbox"/> Memory/Sensory probs	<input type="checkbox"/> Weakness/numbness/tingling
ENDOCRINE:	<input type="checkbox"/> None	<input type="checkbox"/> Unusual changes w/ skin or hair		<input type="checkbox"/> Increased sensitivity to temperature changes	
BLOOD:	<input type="checkbox"/> None	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Swollen hands/feet	<input type="checkbox"/> Swollen glands <input type="checkbox"/> Unusual bruising
IMMUNE:	<input type="checkbox"/> None	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Frequent sinus/ear or respiratory infections	
MENTAL HEALTH:	<input type="checkbox"/> None	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Emotional changes	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Thoughts of hurting self or others

PAST MEDICAL HISTORY

Please indicate any of the following medical conditions you **have now** or have **ever had** in the past:

<input type="checkbox"/> ASTHMA	<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> CHRONIC BRONCHITIS	<input type="checkbox"/> SEASONAL ALLERGIES
<input type="checkbox"/> SINUS INFECTIONS	<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> OSTEOPOROSIS	<input type="checkbox"/> GOUT
<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> STROKE
<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> CHRONIC HEARTBURN	<input type="checkbox"/> GALL BLADDER DISEASE
<input type="checkbox"/> BLEEDING DISORDER	<input type="checkbox"/> ULCERS	<input type="checkbox"/> THYROID DISORDER	<input type="checkbox"/> DIABETES
<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> HEPATITIS (type) _____	
<input type="checkbox"/> DEPRESSION/ANXIETY	<input type="checkbox"/> MENTAL ILLNESS	<input type="checkbox"/> EPILEPSY/SEIZURES	<input type="checkbox"/> MIGRAINES
<input type="checkbox"/> CANCER (type) _____		<input type="checkbox"/> OTHER _____	

STD/HIV HISTORY & RISK FACTORS:

<input type="checkbox"/> NONE	<input type="checkbox"/> UNPROTECTED SEX	<input type="checkbox"/> IV DRUG USE
<input type="checkbox"/> OCCUPATIONAL EXPOSURE	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> TRANSFUSION (Before 1980)
<input type="checkbox"/> CLOSE CONTACT WITH STD/HIV POSITIVE PERSON	<input type="checkbox"/> HISTORY OF PREVIOUS STD (type) _____	<input type="checkbox"/> HEPATITIS (type) _____

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

Please list any surgeries or illnesses you have had in the past:

SURGERY OR ILLNESS	HOSPITAL	YEAR

FAMILY MEDICAL HISTORY

Please complete the following table regarding the medical history of your family members:

	FATHER	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/> BRO <input type="checkbox"/> SIS
Deceased? - If deceased, please list cause of death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AGE (present or at time of death)									
HEALTH HISTORY									
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK/ HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBESITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GALLBLADDER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/ SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA/ BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEPRESSION / ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES: (Please list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Olympus Family Medicine

Scott Neumann D.O., P.A.

CONSENT FOR TREATMENT

I hereby authorize employees and agents; including physicians and physician assistants, of *Olympus Family Medicine* to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice. If the doctor is unable to see me due to appointment availability I may be offered an appointment with the physician assistant.

The duration of this consent is indefinite and continues until revoked in writing or, in the case of minor children, until the child reaches the age of eighteen. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

If patient is a minor:

I give my consent and authorization for *Olympus Family Medicine* to provide medical evaluation and treatment to my child, _____ when I am not available.
(Minor's First & Last Name)

I understand such treatment may include invasive and minor surgical procedures and that the staff of *Olympus Family Medicine* will make reasonable attempts to contact me prior to initiating treatment.

Signature of Patient, Parent, or Legal Guardian **Date**

Please print name _____

Olympus Family Medicine

Scott Neumann D.O., P.A.

PAYMENT POLICY

1. All co-payments, co-insurance and deductibles must be paid at time of service as required by the terms of our contract with your health insurance provider. Please understand that failure on our part to collect these payments can be considered insurance fraud. For your convenience we accept MasterCard, Visa, Discover, and American Express.
2. Please keep in mind that your health insurance policy is a contract between you and your insurance company. As a courtesy to you, we will file your claim with your insurer if you agree to have payment made directly to our practice. If your insurance company does not provide payment within 90 days we will require payment from you. If we later receive a check from your insurer, we will refund any overpayment to you.
3. Please be aware that some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. You will be responsible for payment of all charges for services not covered by your insurance company.
4. All patients must complete our patient registration forms before seeing the doctor. We must obtain a copy of your driver's license and insurance card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the full amount of a claim.
5. When you schedule an appointment, that time is reserved specifically for you. We kindly ask that you provide a minimum of 24 hours notice when cancelling an appointment. If you do not give adequate notice you may be charged \$25.00.
6. You will receive a billing statement from Weaver Medical Billing for any balance that is owed to *Olympus Family Medicine*. All amounts are due upon receipt of this statement. If your account becomes delinquent after 30 days you will be assessed a \$5.00 fee per billing cycle, every 30 days. If it becomes necessary to turn your account over to a collection agency due to delinquency you agree to pay reasonable attorney fees or collection expenses incurred by Olympus Family Medicine. All returned checks will be assessed a \$30.00 returned check fee.
Please call Weaver Medical Billing at the phone number listed on your billing statement for all billing inquiries.

By signing this form I acknowledge I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Signature of Patient, Parent or Legal Guardian

Date

Patient Name

Olympus Family Medicine

Scott Neumann D.O., P.A.

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care.

Olympus Family Medicine is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

HIPAA Effective Date of Notice
April 14, 2003

HIPAA Privacy Act Information Release Form

Please mark below for release of information concerning your healthcare:

Release Information ONLY to me: Yes No

Release of Information to Spouse: Yes No

Spouse's Name: _____

Release of Information to Other Individual: Yes No

Name & Relationship: _____

Phone #: _____

May we leave detailed information on your cell phone? Yes No

May we leave detailed information on your home answering machine? Yes No

May we send appointment reminders via email? Yes No

Email address: _____

By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

Signature of Patient, Parent, or Legal Guardian

Date

Patient Name