8.2-MTBC-F-09

CONFIDENTIAL

ETHERIDGE FAMILY MEDICINE, LLC

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient
◯ Existing Patient

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

DATE ____/____/________ **EMAIL ADDRESS** ____ **HOME PHONE:** (_____) ______-_________

CELL PHONE: (_____) ______-_________

PATIENT'S NAME: ____ , ____ ____________
LAST *FIRST* *MI*

STREET ADDRESS: ____

CITY: _____________________________________ **STATE:** _______________ **ZIP:** ____________________________________

SSN: ______ - ______ - _______ **GENDER:** ◯ *M* ◯ *F* **BIRTH-DATE:** _____/_____/_________ ◯ ***SINGLE*** ◯ ***MARRIED*** ◯ ***DIVORCED*** ◯ ***SEPARATED*** ◯ ***WIDOWED***

Patient Employed By :____

Business Address:____

Occupation:____ **Business Phone:** (_____) ______-__________

Name of Spouse/Responsible Party (If Patient is minor): ______________________________ , ______________________________ __________
LAST *FIRST* *MI*

Spouse/Responsible Party Employed by:____

Business Address:____

Occupation:____ **Business Phone:** (_____) ______-__________

RESPONSIBLE PARTY/SPOUSE SSN : ______ - ______ - _________

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : ____ **ID #:** ________________________**GRP #:**_______________________

***SUBSCRIBER'S NAME:** ____ ***BIRTH DATE:** ______/______/____________

ADDRESS OF PRI. INS. :____

NAME OF SEC. INS. :____ **ID #:** ________________________***GRP #:*** _______________________

***SUBSCRIBER'S NAME:** ____ ***BIRTH DATE:** ______/______/____________

ADDRESS OF SEC. INS. :____

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? ____ Relationship ___________________________________

Person authorized to receive PHI ____ Relationship ___________________________________

PHONE: ***(____)*** ______-_________

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ____hereby authorize____
(NAME OF INSURED) **(NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to ____all benefits, if any, otherwise payable to
(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to ____
(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

____ ___________________________
(AUTHORIZED SIGNATURE OF SUBSCRIBER) **(DATE)**

HEALTH HISTORY
(CONFIDENTIAL)

Name ____________________ Gender ○ M ○ F Date Of Birth ____ /___/_____

Date of last physical examination:____________________ Reason for this visit: _______________

Pharmacy : ______________________________ Tel: ____________________________

SYMPTOMS: Check (x) symptoms you currently have or have had in the past year

General	**Gastrointestinal**	**Eye, Ear, Nose, Throat**	**MEN only**
_Chills	_Appetite Poor	_Bleeding Gums	_Breast Lump
_Depression	_Bloating	_Blurred Vision	_Erection Difficulties
_Dizziness	_Bowel Changes	_Crossed Eyes	_Lump in Testicles
_Fainting	_Constipation	_Difficulty Swallowing	_Penis Discharge
_Fever	_Diarrhea	_Double Vision	_Sore on Penis
_Forgetfulness	_Excessive Hunger	_Earache	_Other
_Headache	_Excessive thirst	_Ear Discharge	**WOMEN only**
_Loss of Sleep	_Gas	_Hay Fever	_Abnormal Pap Smear
_Loss of Weight	_Hemorrhoids	_Hoarseness	_Bleeding Between Periods
_Nervousness	_Indigestion	_Loss of Hearing	_Breast Lump
_Numbness	_Nausea	_Nosebleeds	_Extreme Menstrual Pain
_Sweats	_Rectal Bleeding	_ Persistent Cough	_Hot Flashes
Muscle/Joint/Bone	_Stomach Pain	_Ringing in Ears	_Nipple Discharge
Pain,weakness,numbness in:	_Vomiting	_Sinus Problems	_Painful Intercourse
_ Arms	_Vomiting Blood	_Vision - Flashes	_Vaginal Discharge
_Back _ Legs	**_Cardiovascular**	_Vision - Halos	Other
_Feet _ Neck	_Chest Pain	**Skin**	_LMP Date _________
_Hands _ Shoulders	_High Blood Pressure	_Bruise Easily	_Date of last Pap Smear ______
Genito-Urinary	_Irregular Heart Beat	_Hives	_Have You Had A
_Blood in Urine	_Low Blood Pressure	_Itching	_Mammogram?__________
_Frequent Urination	_Poor Circulation	_Change in Moles	_Are You Pregnant? _______
_Lack of Bladder Control	_Rapid Heart Beat	_Rash	_Number of Children _______
_Painful Urination	_Swelling of Ankles	_Scars	
	_Varicose Veins	_Sore that won't heal	

CONDITIONS: Check (x) conditions you now have or have had in the past.

_Aids	_Chemical Dependency	_High Cholesterol	_Prostate Problem
_Alcoholism	_Chicken Pox	_HTV Positive	_Psychiatric Care
_Anemia	_Diabetes	_Kidney Disease	_Rheumatic Fever
_Anorexia	_Emphysema	_Liver Disease	_Scarlet Fever
_Appendicitis	_Epilepsy	_Measles	_Stroke
_Arthritis	_Glaucoma	_Migraine Headaches	_Suicide Attempt
_Asthma	_Goiter	_Miscarriage	_Thyroid Problems
_Bleeding Disorders	_Gonorrhea	_Mononucleosis	_Tonsillitis
_Breast Lump	_Gout	_Multiple Sclerosis	_Tuberculosis
_Bronchitis	_Heart Disease	_Mumps	_Typhoid Fever
_Bulimia	_Hepatitis	_Pacemaker	_Ulcers
_Cancer	_Hernia	_Pneumonia	_Vaginal Infections
_Cataracts	_Herpes	_Polio	_Venereal Disease

ALLERGIES TO MEDICATIONS or Substances ____

____

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	If deceased, age at death?	If deceased, cause of death?	Check (x) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS/Serious Illness/Injuries			PREGNANCY HISTORY		
Year	Hospital	Reason and Outcome	Year of Birth	Gender of Child	Complication if any

Have you ever had a blood transfusion? __ Yes __ No If yes, please give approximate dates:			Health Habits Check (x) which substances you use and describe how much you use.		
List of Medications	Mg	Quantity		Caffeine	
				Tobacco	
				Drugs	
				Alcohol	
				Other	
			Occupational Concerns Check (x) if your work exposes you to the following:		
				Stress	
				Hazardous Substances	
				Heavy Lifting	
				Other	

Your occupation: ______________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature

______________________________ Date