**Complete**
**Family Medicine**
A service of Hannibal Regional

## New Patient Registration Form

Today's Date: _____

### PATIENT INFORMATION

Patient Name – **Last:** _____ **First:** _____ **MI:** _____
**Previous Last Name (If applicable):** _____ **Preferred Name:** _____
**SSN of Patient:** _____ **Date of Birth:** _____
**Birth Sex:** (M/F)_____ **Current Gender:** _____ **Gender Identity:** _____ **Preferred Pronoun:** _____
**Billing Address:** _____ **City, State:** _____ **Zip Code:** _____
**Physical Address:** _____ **City, Stat:** _____ **Zip Code:** _____
**Phone #:** _____ **Email:** _____
Race: _____ Ethnicity: _____ Language: _____

**Who is your primary care physician?** _____

**In case of emergency, name a friend or relative not living with you:** _____
**Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____
**Relationship:** _____ **Phone:** _____

### RESPONSIBLE PARTY/GUARANTOR

**Name (Last, First, M.I.):** _____ **Phone:** _____ **Cell:** _____
**Address:** _____ **Date of Birth:** _____
**City:** _____ **State:** _____ **Zip Code:** _____ **Sex (M/F):** _____
**SSN#:** _____ **Relationship to Patient:** _____

**Do you have health insurance?** ☐ **Yes** ☐ **No**
**Are you the carrier of the insurance?** ☐ **Yes** ☐ **No** **if no, please complete insured's information.**

### INSURED'S INFORMATION

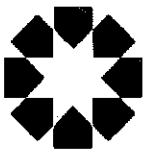
**Name (Last, First, M.I.):** _____ **Phone:** _____ **Cell:** _____
**Date of Birth:** _____ **Relationship to Patient:** _____
**Name of Insurance:** _____ **Policy #:** _____ **Group #:** _____

**Do you have secondary/supplemental health insurance?** ☐ **Yes** ☐ **No**
**Are you the carrier of the insurance?** ☐ **Yes** ☐ **No** **if no, please complete insured's information or (same as above).**
**Name (Last, First, M.I.):** _____ **Phone:** _____ **Cell:** _____
**Date of Birth:** _____ **Relationship to Patient:** _____
**Name of Insurance:** _____ **Policy #:** _____ **Group #:** _____

By signing below, I certify that all information submitted is correct to the best of my knowledge.

**Patient/Guardian Signature:** _____ Date: _____
**Witness** (CFM Representative): _____ Date: _____

Office Use Only:
EPM _____



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Patient Name: _____ DOB: _____

Phone Number: _____ Email: _____

Address: _____

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize and direct Complete Family Medicine, a service of Hannibal Regional Healthcare System, Inc. ("CFM") to disclose all or part of my medical record to my anticipated payor which could be my employer, insurance company/ies, the Health Care Financing Administration, Medicare, Medicaid and its or their related agents as necessary to verify or process claims for insurance and third party payment. CFM may also release information as required by applicable law or as necessary or helpful for continuation of my care which includes participation in health information exchanges. I also understand my healthcare information will be aggregated into a health tool for data analysis, health registries and quality improvement opportunities.

## AGREEMENT TO PAY

In consideration for services provided, each of the undersigned (including the patient, their spouse, person signing as patient's representative, and / or parent or guardian of unemancipated minor) agrees to pay all charges of CFM, its clinicians and independent contractors. Each bill is due upon presentation or mailing to the patient or any of the undersigned. If any bill becomes delinquent, the undersigned agrees to pay all collection agency and attorneys' fees and court costs and other costs of collection. If suit is filed to collect, it may be filed in the county where this agreement was signed.

## INSURANCE ASSIGNMENT AND CONSENT TO TREATMENT

The undersigned hereby assigns all monies payable or to be paid by any insurance company/ies, individuals, corporations or any source whatsoever for services rendered to the patient named below to CFM.
I request and consent to receive treatment from CFM. I understand CFM is staffed by a healthcare team which may include physicians, assistants, nurse practitioners, nurses and technicians. I freely accept care from this team and acknowledge the establishment of the provider–patient relationship. I understand this healthcare team will provide information and/or care; however, I maintain the right to make all decisions about my care. This consent is to remain in effect until revoked by me in writing. I understand I have the right to revoke this consent at any time.

## ELECTRONIC COMMUNICATIONS

By initialing,
_____ I consent to CFM contacting me for quality improvement measures by phone, text or email.
_____ I consent to CFM contacting me for collection matters by text.

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES BROCHURE

I acknowledge I have received a copy of CFM's Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure. These notices describe how my health information may be used or disclosed and my rights and responsibilities as a patient. I understand I should read them carefully. I am aware the notices may be changed at any time and that I may obtain a revised copy by contacting CFM.
I certify I understand and agree to the provisions contained in this agreement.

Patient Signature: _____ Date of Signature: _____

Witness: _____ Witness' Printed Name: _____

**If not signed by the patient, please confirm:**

Name: _____ Relationship to Patient: _____

Address: _____ Phone: _____

## HIPAA DISCLOSURE

____ Do Not Release My Health Information. _____ Release My Health Information as follows:
CFM does not require you to complete a HIPAA authorization as a condition for treating you. This authorization is voluntary unless the specific nature of the healthcare is to create information for disclosure (such as an employment physical or independent insurance exam). I understand I have the right to revoke this authorization at any time by submitting written notice, except for any action already taken in reliance on the authorization. I also understand any disclosure I allow may be subject to redisclosure by the recipient and no longer be protected by HIPAA. If I do not revoke this authorization, it will expire in one year from signature. I authorize the disclosure and use of my protected health information to the extent necessary to allow my designated others to discuss my issues when I need help understanding those issues; to pick up medications, prescriptions or results; or to make or manage appointments. It also allows the individual to bring the patient to appointments and consent to treatment. This consent does not grant full access to my medical records.

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Signature if authorizing Health Information Release: _____ Date: _____

# Complete Family Medicine

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| Office Use Only | Room # _____ |
|---|---|
| Immunization: _____ | Preventative: ____ |
| Meds Reviewed ____ | List ____ Verbal |

Patient Name: _____ Date of Birth: _____

Why are you seeing us today? _____

**Is this work related? YES ____ NO ____ Have you had the COVID Vaccine? YES_____ NO _____**

Current Medications: _____

Pharmacy: _____ Allergies: _____

| |
|---|
| Ht - |
| Wt - |
| Temp - |
| P - |
| R - |
| BP - |
| O2 Sat – |
| Pain Scale - |

**Please Circle if you are experiencing any of these symptoms:**

**Constitutional**:
Excess fatigue, fever, night sweats

**HEENT**:
Eye discharge and vision loss
Ear drainage, hearing loss, nasal drainage

**Respiratory**:
Cough, shortness of breath, wheezing

**Cardiovascular**:
Chest pain, pain in your legs while walking,
irregular heartbeat/palpitations

**Gastrointestinal**:
Abdominal Pain, constipation, diarrhea, vomiting

**Genitourinary/Reproductive**:
Pain with urination, blood in your urine,
increased urinary frequency
**MEN**: Penile discharge
**WOMEN**: Pain with menstruation, excessive
bleeding, vaginal discharge

**Metabolic/Endocrine**:
Cold intolerance, heat intolerance, increased drinking,
increased appetite

**Neuro/Psychiatric:**
Trouble walking, psychiatric symptoms

**Dermatologic:** Itch, rash

**Musculoskeletal**:
Bone/joint symptoms, muscle weakness

**Hematology**:
Bleeding, easy bruising
**Immunology**: Environmental allergies, drug allergies

**M99.O** OA, F E, RR RL, SR SL
**M99.01** C 2345 6 7, F E RRRL, SR SL
**M99.02** T 1 2 3 4 5 6 7 8 9 10 11 12 N F E,
RR RL, SR SL
**M99.03** L 2 3 4 5, NF E, RR RL, SR SL
**M99.04** S L R on L R or L R Shear-sup, inf
**M99.05** P L R, ant post shear-sup
**M99.06** LE
**M99.07** UE
**M99.08** Rib L R, 1 2 3 4 5 6 7 8 9 12 inhaled
exhaled
**M99.09** Other

# Complete Family Medicine

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Date: _____

Provider's Initials ____

Abstracted By _____

(updated 07/20/22 MLA)

## PEDIATRIC HEALTH HISTORY
## (11 years old & under)

| **Patient Name** *(Last, First, MI):* | | | **Date of Birth:** |
|---|---|---|---|
| **Birth Sex:** □ Male □ Female | **Current Gender:** | **Gender ID:** | **Pref Pronoun:** |
| **Child's Prev Dr or PCP:** | **Date of Last Dental Exam:** | | **Date of Last Physical Exam:** |

| **MEDICATIONS (Prescription and over-the-counter drugs such as vitamins and inhalers)** | | |
|---|---|---|
| **Name of Drug** | **Strength** | **Frequency** |
| | | |
| | | |
| | | |
| | | |

| **ALLERGIES TO MEDICATIONS** | |
|---|---|
| **Name of Drug** | **Reaction you had** |
| | |
| | |
| | |

**PAST MEDICAL HISTORY (Do you now have or have ever had:) □ NONE APPLY**

| | | | |
|---|---|---|---|
| □ Allergies | □ Depression | □ High Blood Pressure | □ Leukemia |
| □ Asthma | □ Diabetes (type)_____ | □ High Cholesterol | □ Psoriasis |
| □ Anemia | □ Epilepsy/Seizure Disorder | □ HIV/AIDS | □ Stroke |
| □ Anxiety | □ Headaches | □ Hypothyroidism | □ Tuberculosis |
| □ Cancer (type)_____ | □ Heart Murmur | □ Jaundice | Other (Please Specify): |
| □ Developmental delays | □ Heart Problems | □ Mental Illness | |

**CHLDHOOD ILLNESSES:** □ Mumps □ Measles □ Rubella □ Polio □ Rheumatic Fever □ Chicken Pox

| **HOSPITALIZATIONS & SURGERIES** | | |
|---|---|---|
| **Year** | **Reason** | **Hospital** |
| | | |
| | | |
| | | |
| | | |

| **IMMUNIZATIONS AND DATES:** | | | | | |
|---|---|---|---|---|---|
| □ Tetanus | □ Influenza | □ Pneumonia | □ MMR | □ Hepatitis | □ Chicken Pox |
| | | | | | |

## FAMILY HEALTH HISTORY

| | AGE | Significant Health Problems | | AGE | Significant Health Problems |
|---|---|---|---|---|---|
| Father | | | Children | □ M | |
| | | | | □ F | |
| Mother | | | | □ M | |
| | | | | □ F | |
| Sibling | □ M | | | □ M | |
| | | | | □ F | |
| | □ F | | Grandmother *(Maternal)* | | |
| | □ M | | Grandfather *(Maternal)* | | |
| | □ F | | Grandmother *(Paternal)* | | |
| | □ M | | Grandfather *(Paternal)* | | |
| | □ F | | | | |

## RELATIONSHIPS

| | Provider | Days/ Week | | Provider | Days/Week | |
|---|---|---|---|---|---|---|
| Primary childcare Provider/s | □ Mother | | | □ Daycare | | |
| | □ Father | | | □ Sitter | | |
| | □ Grandparent | | | □ Self | | |
| | □ Sibling/s | | | □ Relative | | |
| | □ Nanny | | | □ Friend | | |

**Who lives in the home? Please list below**

| Relationship | Age | Name |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| Any concerns about relationships with family, friends or others? | □ Yes | □ No |
| If yes, please explain: | | |

## HEALTH HABITS AND PERSONAL SAFETY

| | | | |
|---|---|---|---|
| Exercise | □ Sedentary (no regular exercise) | | |
| | □ Occasional exercise | | |
| | □ Regular exercise | | |
| Diet | Was your child breastfed? For how long? _____ | □ Yes | □ No |
| | Has your child had any feeding/dietary problems? | □ Yes | □ No |
| | If yes, explain | | |
| | Daily milk/Formula intake □ Cow's Milk □ Rice Milk □ Soy Milk □ Other | | |
| | □ Nonfat □ 1% □ 2% □ Whole Average oz /day? _____ | | |
| Personal Safety | Does your child where a helmet when riding a bike/ATV/scooter | □ Yes | □ No |
| | Are there carbon monoxide detectors in the home? | □ Yes | □ No |
| | Are there smoke detectors in the home? | □ Yes | □ No |
| | Is violence at home a concern? | □ Yes | □ No |
| | Are there firearms in the home? | □ Yes | □ No |

Patient Name: _____ DOB: _____ Provider Initials: _____

| | | | |
|---|---|---|---|
| | Are there concerns about lead exposure in the home? (old home/peeling paint) | □ Yes | □ No |
| | Do family members smoke/vape in the home? | □ Yes | □ No |
| | When your child is in the car, does he/she use; □ Rear face Infant seat □Front Face infant seat | | |
| | □ Booster seat □ Seat belt only | | |
| Sleep | Does your child take naps? | □ Yes | □ No |
| | Does your child sleep through the night? | □ Yes | □ No |
| | Any concerns with sleep problems/nightmares? | □ Yes | □ No |
| Dental Hygiene | Did/does your child use a pacifier? | □ Yes | □ No |
| | If so, for how long _____ What age did he/she stop _____ | | |
| | How often does your child have fluoride applied to their teeth? | | |
| | Any history of cavities? | □ Yes | □ No |

| EDUCATION | | |
|---|---|---|
| Did/does your child attend school or preschool? | □ Yes | □ No |
| Any concerns about school performance? | □ Yes | □ No |
| If yes, please explain: | | |
| Any concerns about relationships with teachers? | □ Yes | □ No |
| Any concerns about relationships with other students? | □ Yes | □ No |
| Does your child like school? | □ Yes | □ No |
| Performing in school: □ Below grade level □ At grade level □Above grade level | | |

| PREGNANCY AND BIRTH | | |
|---|---|---|
| Where was your child born: (Facility name and city/state) | | |
| Birth Weight: Birth Length: | | |
| Is the child yours by: □ Birth □ Adoption □ Step □ Foster □ Other: | | |
| Feeding: □ Breast □ Bottle □ Formula – type; - _____ | | |
| Any complications during birth? | | |
| If yes, explain: | | |
| | | |
| Did mother receive prenatal care? | □ Yes | □ No |
| Multiple Birth? | □ Yes | □ No |
| Vaginal Delivery? | □ Yes | □ No |
| Caesarean Delivery? | □ Yes | □ No |
| Did the child stay in the NICU? | □ Yes | □ No |
| If so, how long? | | |
| Did your child receive Hepatitis B and Vitamin K vaccines in the Hospital? | □ Yes | □ No |
| Did your child pass or fail hearing test in the hospital? | □ Pass | □ Fail |
| Any birth defects at birth? | □ Yes | □ No |
| If so, please explain, | | |
| | | |
| At what age did your child: | | |
| Sit alone:_____ Walk alone: _____ Say words: _____ Toilet Train: _____ | | |
| **Girls only**: Age of first menstrual period: _____ | | |
| | | |

**Any other concerns that you would like to discuss with your child's provider:**

Patient Name: _____ DOB: _____ Provider Initials: _____