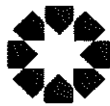


Complete
Family Medicine
A service of Hannibal Regional

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:** ______________________

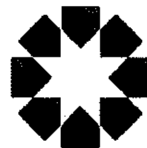
Name of Insurance: ____________________________________ **Policy #:** ___________________________**Group #:** _______________

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 _______



Complete Family Medicine

A service of Hannibal Regional

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
A service of Hannibal Regional

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

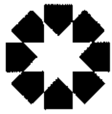
Neuro/Psychiatric:
Trouble walking, psychiatric symptoms

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
A service of Hannibal Regional

Date: ____________

Provider's Initials: ________

Abstracted By: ________

(updated 01/11/24 MLA)

ADULT HEALTH HISTORY
(12 years old and over)

Patient Name *(Last, First, MI):*			Date of Birth:
Birth Sex: ☐ Male ☐ Female	Current Gender:	Gender ID:	Pref Pronoun:
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Prev/referring Dr.:			Date of Last 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	☐ Liver Disease
☐ Angina	☐ Diabetes (type)________	☐ High Cholesterol	☐ Pneumonia
☐ Asthma	☐ Emphysema/COPD	☐ HIV/AIDS	☐ Psoriasis
☐ Anemia	☐ Epilepsy/Seizure Disorder	☐ Hypothyroidism	☐ Pulmonary Embolism
☐ Anxiety	☐ Goiter	☐ Jaundice	☐ Rheumatic Fever
☐ Arthritis	☐ Headaches	☐ Kidney Disease	☐ Stomach/Peptic Ulcer
☐ Cancer (type)________	☐ Heart Murmur	☐ Kidney Stones	☐ Stroke
☐ Colitis	☐ Heart Problems	☐ Leukemia	☐ Tuberculosis
☐ Crohn's	☐ Hepatitis	Other (Please Specify):	☐ AFIB

HOSPITALIZATIONS & SURGERIES

Year	Reason	Hospital

HEALTH HABITS AND PERSONAL SAFETY

Exercise	□ Sedentary (no regular exercise)			
	□ Occasional exercise			
	□ Regular exercise			
Diet	Are you on a special diet?		□ Yes	□ No
	If yes, please describe			
	Daily salt intake	□ Low	□ Medium	□ High
	Daily fat intake	□ Low	□ Medium	□ High
Tobacco/ Nicotine	Do you use Tobacco?		□ Yes	□ No
	□ Cigarettes pks/day	□ Chew – times/day ____	□ Pipe - #/day ____	□ Cigars - #/day ____
	# of years ____	# years quit ____	Vape? - times/day ____	
Alcohol	Do you drink alcohol?		□ Yes	□ No
	How many drinks per week?			
	When was your last drink?			
	What kind of alcohol do you drink?			
	Are you concerned about the amount that you drink?		□ Yes	□ No
Caffeine	□ None	□ Coffee	□ Tea	□ Soda
	Cups / day ____			
Drugs	Do you currently use recreational or street drugs?		□ Yes	□ No
	Have you ever given yourself street drugs with a needle?		□ Yes	□ No
Sex	Are you sexually active?		□ Yes	□ No
	If yes, are you trying to get pregnant?		□ Yes	□ No
	If not trying for pregnancy, list contraceptive or barrier method used:			
	Would you like to speak with your provider about your risk for HIV/AIDS?		□ Yes	□ No
Personal Safety	Do you live alone?		□ Yes	□ No
	Do you have frequent falls?		□ Yes	□ No
	Do you have vision or hearing loss?		□ Yes	□ No
	Do you have an Advance Care Directive or Living Will?		□ Yes	□ No
	Would you like to discuss with your provider about any other issues involving physical/sexual/verbal abuse?		□ Yes	□ No

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				

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

IMMUNIZATIONS AND DATES:

□ Tetanus	□ Influenza	□ Pneumonia	□ MMR	□ Hepatitis	□ Chicken Pox

Patient Name: ____________________ DOB: ______________ Provider Initials: __________

MENTAL HEALTH		
Is stress a major problem for you?	□ Yes	□ No
Do you feel depressed?	□ Yes	□ No
Do you panic when stressed?	□ Yes	□ No
Do you have problems with eating or your appetite due to stress?	□ Yes	□ No
Do you cry frequently?	□ Yes	□ No
Have you ever attempted suicide?	□ Yes	□ No
Have you ever seriously thought about hurting yourself?	□ Yes	□ No
Do you have trouble sleeping?	□ Yes	□ No
Have you ever been to a counselor?	□ Yes	□ No

WOMEN ONLY		
Age at onset of menstruation:	Date of last Menstruation:	
Average period is ____ days.		
Heavy periods, irregularity, spotting, pain or discharge?	□ Yes	□ No
Are you currently pregnant?	□ Yes	□ No
Are you currently breastfeeding?	□ Yes	□ No
Have you had a D&C, hysterectomy or cesarean?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Any problems with control of bladder?	□ Yes	□ No
Any hot flashes or night sweats?	□ Yes	□ No
Do you have menstrual pain, tension, bloating, irritability or other concerns around your period?	□ Yes	□ No
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	□ Yes	□ No
Number of pregnancies ________________	Number of live births ______________________	
Date of last Pap _______________________	Date of last Mammogram __________________	

MEN ONLY		
Do you usually get up to urinate during the night? If yes, # of times ______________	□ Yes	□ No
Do you feel pain or burning with urination?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Do you feel burning discharge from your penis?	□ Yes	□ No
Has the force of your urination decreased?	□ Yes	□ No
Have you had any kidney, bladder or prostate infections w/in the last 12 months?	□ Yes	□ No
Do you have any problems emptying your bladder completely?	□ Yes	□ No
Any difficulty with erections or ejaculation?	□ Yes	□ No
Any testicle pain or swelling?	□ Yes	□ No
Date of last prostate and/or rectal exam: _______________________		

Other Pain/Discomfort/Concerns: ____

What other doctors, specialists, or alternative healthcare providers do you currently see or have you seen in the past?

____

PATIENT HEALTHCARE DIRECTIVE INFORMATION

Do you have an Advance Healthcare Directive? (Ex: Durable Power of Attorney, Living Will) __ Yes __ No
I will provide a copy of my Advance Healthcare Directive? __ Yes __ No
Would you like to receive information on Advance Healthcare Directives? __ Yes __ No

Patient Name: _________________________________ DOB: _______________________ Provider Initials: _____________