Complete
Family Medicine
A service of Hannibal Regional

Office Use Only:
EPM _____

Authorization to Release Medical Information

For purpose of reimbursement, Complete Family Medicine is hereby authorized and directed to disclose all or any part of the medical record to my employer, my insurance companies, the Health Care Financing Administration and its agents, Medicaid, or any other agencies as may be necessary to verify or process any and all claims for insurance coverage for third party reimbursement. This Clinic may also release information as may be necessary for continuation of care.

Insurance Assignment and Consent to Treatment

The undersigned hereby assigns all monies payable or to be paid by any insurance company(ies), individual(s), corporation(s), or from any source whatsoever for services rendered to the below patient of Complete Family Medicine a service of HRHS. I hereby request and consent to receive treatment from this Hannibal Regional Health System Service. I understand that this clinic is staffed by a healthcare team, which may include a physician(s), nurse practitioner(s), nurses and technicians. I freely accept care from this healthcare team and acknowledge the establishment of the provider-patient relationship. I further understand that this healthcare team will provide information and/or care including but not limited to, medical history, physical examination, assessments of health status, laboratory and diagnostic testing, emergency procedures, suturing, prescription medications, and immunizations; however, I maintain the right to make all decisions regarding my care. This consent is to remain in effect until I revoke it in writing. I understand that I have the right to revoke this consent at any time.

Agreement to Pay

In consideration of services provided, each of the undersigned (including the person signing as a representative for the patient is the patient, is his/her spouse, unemancipated child or other lawful dependent) agrees to pay all charges of Complete Family Medicine and independent contractors. Each bill is due and payable upon presentation or mailing of the same to either the patient or any of the undersigned. If any bill becomes delinquent, the undersigned agrees to pay all collection agency fees, all attorney's fees and all other collection expenses incurred by Complete Family Medicine and/or the independent contractors. If suit is filed to enforce collection, it may be filed in the county where the agreement is being signed and entered into.

Initial Here: _____ I acknowledge that I have read the Financial Policy that is posted and understand my financial obligations regarding my visit(s) to Complete Family Medicine. A copy of the policy is available upon request.

PATIENT RIGHTS

I acknowledge that I have received a copy of my patient rights. (Please initial) _____
Do you have an Advance Healthcare Directive? (Durable POA, Living Will) ☐ Yes ☐ No
A copy of my Advanced Healthcare Directive will be provided to the clinic? ☐ Yes ☐ No
Would you like to receive information on Advance Healthcare Directive? ☐ Yes ☐ No

HIPAA DISCLOSURE

I give CFM permission to share or discuss my health information (including your condition, plan of care, labs, x-rays, appointments etc.) with the following family, friends or others who will be involved in my care or payment for care. If releasing information to anyone, including those listed below, for purposes other than for care or payment, I understand I will be required to sign a separate Medical release form.

Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____
Full Name: _____ Relationship to Patient: _____

By signing below, I acknowledge that I have received a copy of Complete Family Medicine's Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure. The Notices describe how my health information may be used or disclosed and my rights and responsibilities as a patient of CFM/HRHS. I understand that I should read them carefully. I am aware that the Notices may be changed at any time and that I may obtain a revised copy of the Notices by contacting CFM/HRHS.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE PROVISIONS CONTAINED WITHIN THIS AGREEMENT

PRINT Patient's Name: _____ **Date of Birth**: _____

PATIENT/GUARDIAN SIGNATURE: _____ **Today's Date**: _____
Witness (CFM Representative): _____ Today's Date: _____

If you are signing for the patient, please complete the following information:

Name: _____ Date of Birth: _____
Relationship to the Patient: _____ Phone: _____

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New Patient Registration Form

Today's Date: _____

PATIENT INFORMATION

Patient Name – **Last:** _____ **First:** _____ **MI:** _____
SSN of Patient: _____ **Date of Birth:** _____ **Sex:** (M/F)_____
Address: _____ **City, State:** _____ **Zip Code:** _____
Phone #: _____ **Email:** _____
Race: _____ Ethnicity: _____ Language: _____

Are you currently employed? ☐ Yes ☐ No Employer's Name: _____
Employer's Address: _____ Employer's Phone: _____
In case of emergency, name a friend or relative not living with you: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Relationship: _____ Phone: _____ **Who is your primary care physician? :** _____

RESPONSIBLE PARTY

Name (Last, First, M.I.): _____ Phone: _____ Cell: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip Code: _____ Sex (M/F): _____
SSN#: _____ Relationship to Patient: _____
Is the responsible party currently employed? ☐ Yes ☐ No Employer's Name: _____
Employer's Address: _____ Employer's Phone: _____

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: _____
Address: _____ Date of Birth: _____
SSN#: _____ Employer: _____ 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: _____
Address: _____ Date of Birth: _____
SSN#: _____ Employer: _____ Relationship to Patient: _____
Name of Insurance: _____ **Policy #:** _____ **Group #:** _____

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

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Immunization: _____ Preventative: ____
Meds Reviewed_____
(Circle one)
List Verbal Pharmacy

Patient Name: _____ Date of Birth: _____

Why are you seeing us today? _____

_____

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 and nasal drainage

Respiratory:
Cough, shortness of breath and wheezing

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

Gastrointestinal:
Abdominal Pain, constipation, diarrhea and 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 and increased appetite

Neuro/Psychiatric:
Trouble Walking
Psychiatric Symptoms

Dermatologic: Itch, Rash

Musculoskeletal:
Bone/joint symptoms and muscle weakness

Hematology:
Bleeding and 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

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Date: _____
Provider's Initials ____
Abstracted By _____

PEDIATRIC HEALTH HISTORY

Patient's Full Name: _____ ☐Male ☐Female D.O.B ___/___/___ Age: ____
Child's Previous Doctor/Primary Care Provider: _____
Present Health Concerns: _____

Current Medications/Vitamins: _____
Herbs/Home Remedies: _____
Allergies/Reactions to Medications or Vaccinations: _____

PREGNANCY & BIRTH

Where was your child born? Facility: _____ City/State _____
Is the child yours by: Birth Adoption Step Child Other: _____
Please indicate any medical problems during pregnancy: NONE
Specify: _____
Delivery by: Vaginal Birth Caesarean If Caesarean, Why? _____
Birth Weight: _____ Birth Length: _____ APGAR Score 1min: ___ 5 min: _____
Please indicate any medical problems during the baby's newborn period: NONE
Specify: _____

NUTRITION & FEEDING

Was your child breastfed? NO YES If so, how long? _____
Has your child had any feeding/dietary problems? NO YES If yes, Specify: _____
_____
_____
Current Milk Intake: _____ Type: Cow's Milk (Nonfat 1% 2% Whole)
Soy Milk
Rice Milk
Average ounces per day (note 8 ounces = 1 cup): _____

SLEEP

Hours per night: _____ Naps (number and length) _____
Any sleep problems: _____

DEVELOPMENT

At what age did your child:
Sit alone: _____ Walk alone: _____ Say words: _____ Toilet Train (daytime):_____
Girls only: age at first menstrual period: _____

DENTAL HISTORY

Has your child been seen by a dentist? NO YES
If so, how often? _____ Date of last visit: _____
Water source: City or Well? _____

IMMUNIZATIONS/INFECTIOUS DISEASES: PLEASE BRING YOUR CHILD'S IMMUNIZATION RECORDS TO YOUR APPOINTMENT.

Has your child had: Chicken Pox Measles Mumps Rubella Meningitis Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (Old home/plumbing/peeling paint) NO YES
Do any household members smoke? NO YES
TV hours per day: _____ Computer hours per day _____ Video game hours per day _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

_____
_____
_____
Hospitalizations/operations with dates: _____
Broken bones or Severe Sprains: _____

FAMILY HISTORY: Please indicate the status of your immediate family members with any of the following conditions (parent, sibling, grandparent, aunt or uncle):

Alcholism _____ High Cholesterol _____
Cancer, Specify type _____ High Blood Pressure _____
Heart Attack _____ Stroke _____
Depression/Suicide _____ Other _____
Diabetes _____ Other _____

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Child Care Situation Parents Others (Specify who and hours per day) _____
Concerns about your child: Alcohol Use Tobacco Aggressive Behavior Sexual Activity

Is violence at home a concern? NO YES Are there guns in the home? NO YES

SCHOOL HISTORY:

Did/does your child attend school or preschool? NO YES
Current Grade: _____ Name of School: _____
Any concerns about school performance? _____
Any concerns about relationships with: Teachers: NO YES
Students: NO YES
If more than 4 years old, does your child have a best friend? NO YES

SPORTS/EXERCISE: Type _____ How Often ? _____ How long (minutes) _____

SAFETY:

When you child is in the care does he/she use: Infant Seat Booster Seat Seat belt only
Does your child wear a helmet when riding his/her bike, scooter or ATV? NO YES
Do you have smoke detectors at home? NO YES

REVIEW OF SYMPTOMS: Please check any current problems you child has from the list below:

Constitutional
Fever/chills/excessive seating
Unexplained weight gain/loss

Eyes
Squinting/crossed eyes

Ears/Nose/Throat
Unusually loud voice/
Hard of hearing
Bad Breath
Frequent Runny Nose
Problems with teeth/gums

Cardiovascular
Tires Easily with Exercise
Shortness of Breath
Fainting

Gastrointestinal
Nausea/vomiting/diarrhea
Constipation
Blood in bowel movements

Genitourinary
Bedwetting
Pain with urination
Discharge from Penis or vagina

Musculoskeletal
Muscle/Joint Pain

Skin
Rashes
Unusual Moles

Respiratory
Cough/Wheeze
Chest Pain

Neurological
Headaches
Weakness
Clumsiness
Psychiatric/Emotional
Speech Problems
Anxiety/Stress
Problems with Sleep/Nightmares
Depression
Nail biting/thumb sucking
Bad Temper/Jealousy

Blood/Lymph
Unexplained lumps
Easy bruising/bleeding

Allergy
Hayfever/Itchy watery eyes