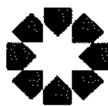

New Patient Registration Form

Today's Date: ____________

PATIENT INFORMATION

Patient Name – **Last:** ______________________ **First:** ______________________ **MI:** __________

Previous Last Name (If applicable): ______________________ **Nick Name:** ____________________

SSN of Patient: ____________________ **Date of Birth:** __________________

Birth Sex: (M/F)_____ **Current Gender:** ______ **Gender Identity:**________ **Preferred Pronoun:**__________

Address: ______________________ **City, State:** __________________ **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

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: ________________

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A service of Hannibal Regional

Office Use Only:
EPM ________

Patient Name: ______________________________ **DOB:** ______________
Address: ______________________________
____
Phone Number: ______________________

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.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

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.

HIPAA DISCLOSURE

By signing below, I also give CFM/HRHS 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: ______________

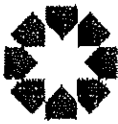
I CERTIFY THAT I UNDERSTAND AND AGREE TO THE PROVISIONS CONTAINED WITHIN THIS AGREEMENT

PATIENT ***OR*** *PARENT/GUARDIAN SIGNATURE*: ______________________ **Today's Date**: __________
Witness (CFM Representative): ______________________ **Today's Date:** __________

If you are not the patient, please complete the following information:

Print Guardian/Guarantor: Name: ______________________________
Relationship to the Patient: ______________________ Phone: ______________

Revised 03.10.2022 MA



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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

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Date: ____________
Provider's Initials: ________
Abstracted By: ________
(updated 07/20/22 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):	

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 Name: __________________________________ DOB: ________________________ Provider Initials: _______________