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): ____________ **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: ____________

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

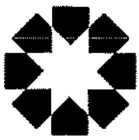
Dermatologic: Itch, rash

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

Revised 11/18/2021 - MA



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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

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	□ Yes
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:

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____

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Patient Name: ______________________ DOB: ______________ Provider Initials: __________