



## New Patient Registration Form

Thank you for visiting Vinings Medical Center. In order to generate your basic medical record, please complete this and all attached forms in their entirety. Feel free to let us know if you have any questions while completing the forms.

### Patient Information

\_\_\_\_\_  
*Patient name (Last, First)*

\_\_\_\_\_  
*Patient date of birth*    *Patient gender (M / F)*    *Patient marital status*

\_\_\_\_\_  
*Mailing address (address number & street)*

\_\_\_\_\_  
*Patient Social Security Number*    *Employment / student status*

\_\_\_\_\_  
*Mailing address (apartment no., etc.)*

\_\_\_\_\_  
*Employer or school name*

\_\_\_\_\_  
*City, State, ZIP-Code*

\_\_\_\_\_  
*Work telephone (incl. extension)*

\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*When we need to leave a message – which number may we use?*

\_\_\_\_\_  
*E-Mail address*

\_\_\_\_\_  
*Do you have a living will?*    *Would you like information on one?*

### Guarantor Information (skip if same as patient)

*(The guarantor is the person holding your insurance plan or responsible for payment)*

\_\_\_\_\_  
*Guarantor name (Last, First)*

\_\_\_\_\_  
*Guarantor date of birth*    *Guarantor Gender (M / F)*

\_\_\_\_\_  
*Mailing address (address number & street)*

\_\_\_\_\_  
*Guarantor Social Security Number*

\_\_\_\_\_  
*Mailing address (apartment no., etc.)*

\_\_\_\_\_  
*Relationship to patient*

\_\_\_\_\_  
*City, State, ZIP-Code*

\_\_\_\_\_  
*Work telephone (incl. extension)*

\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*Employer name*

\_\_\_\_\_  
*E-Mail address*

\_\_\_\_\_  
*May we leave a message at work?*

### Emergency Contact Information

\_\_\_\_\_  
*Name (Last, First)*

\_\_\_\_\_  
*May we disclose necessary medical information to this person?*

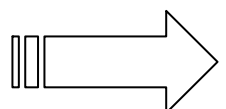
\_\_\_\_\_  
*Home telephone*

\_\_\_\_\_  
*Cell phone*

\_\_\_\_\_  
*Your relationship to this person*

\_\_\_\_\_  
*Work telephone (incl. extension)*

**Next page, please**



## Primary Insurance Information

Insurance Name \_\_\_\_\_

Relationship of patient to insured:  Self  Spouse  Dependent Child  Other: \_\_\_\_\_

Complete mailing address of insured if different than patient or guarantor \_\_\_\_\_

## Secondary Insurance Information

Insurance Name \_\_\_\_\_

Relationship of patient to insured:  Self  Spouse  Dependent Child  Other: \_\_\_\_\_

Complete mailing address of insured if different than patient or guarantor \_\_\_\_\_

## Pharmacy Information

Pharmacy Name \_\_\_\_\_

Pharmacy Telephone \_\_\_\_\_

Complete address of pharmacy \_\_\_\_\_

In signing below, I confirm my understanding that:

1. PCP ELECTION: If my insurance company requires a PCP election, I have called my insurance company prior to or during my (or my dependent's) office visit and have selected Dr. Smith as my (or my dependent's) PCP and the effective date of this change (as notified by my insurance company) is on or before the date of my (or my dependent's) first visit.
2. CO-PAYMENT AND ANNUAL DEDUCTIBLE POLICY: Vinings Medical Center, P.C. requires payment at time of service for any foreseen amount not covered by my or Patient's insurance (including co-payments, co-insurance and unmet annual deductibles).
3. APPOINTMENT CANCELLATION POLICY: I understand Vinings Medical Center, P.C. requires a twenty-four (24) hour notice of cancellation for any appointment. Should I fail to provide such notice I agree to pay a \$50.00 no-show charge in consideration for my lack thereof.
4. CLAIMS FILING AGREEMENT AND ASSIGNMENT OF BENEFITS:
  - a. NON-MEDICARE INSURANCE: I authorize Vinings Medical Center, P.C. to file insurance claims on behalf of the Patient and assign associated benefits to Vinings Medical Center.
  - b. MEDICARE INSURANCE: I authorize any holder of medical or other information about Patient to release to the Social Security Administration and Health Care Financing Administration, its intermediaries, or its carrier(s) any information required to process a Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party accepting assignment. Regulations pertaining to Medicare assignment of benefits apply.
5. FINANCIAL AGREEMENT: I am ultimately responsible for payment of all sums owed Vinings Medical Center, P.C. relating to the services provided to the patient identified herein [the "Patient"]. I understand and agree that I must pay all charges on the Patient's account which are not covered by insurance, including, but not limited to co-payments, insurance deductibles, co-insurance, PCP changes taking effect after Patient's office visit, and those charges which insurance fails to pay or refuses to cover. I understand and agree that I will pay all sums within thirty (30) days of invoice date, and that sums not paid within this time shall incur a \$5.00 rebilling fee (per additional statement) and accrue interest from the original date(s) of service at the rate of 1.5% per month. In the event sums owed are not paid when due, I understand and agree that I will be responsible for all reasonable costs incurred by Vinings Medical Center, P.C. in the collection of sums owed on the Patient's account, including collection agency fees, attorney's fees and court costs, if applicable. I further acknowledge: a) I will incur a service charge of \$35.00 for each check which I submit to Vinings Medical Center, P.C. which is not honored by presenter's financial institution; b) for each dishonored check, I agree to pay by cash or cashier's check, the amount of the returned check, plus the service charge, within seven (7) days of notification of the dishonored check; c) any returned check on a self-pay account which received the "self-pay at time of service discount" will have this discount reversed; and d) no additional credit will be extended to myself or the Patient with a balance past-due on the Patient's account.
6. PRIVACY PRACTICES: I may review Vinings Medical Center's Notice of Privacy Practices at any time.
7. AUTHORIZATION TO TREAT: I give Dr. Smith, Vinings Medical Center, its agents, employees, and contractors authorization to treat the patient listed herein.

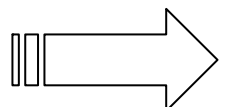
I have read, understand and agree to these terms.

Signature of Patient or Patient's Responsible Party \_\_\_\_\_

Patient or Patient's Responsible Party Name (please print) \_\_\_\_\_

Today's Date \_\_\_\_\_

**On to privacy form, please**





## Consent to Use and Disclosure of Protected Health Information

We are providing you this notice in accordance with applicable law. If you have any questions, please feel free to let us know.

- 1. Use and Disclosure of Your Protected Health Information:**  
Your protected health information will be used by Vining's Medical Center, P.C. and may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.
- 2. Notice of Privacy Practices:**  
Upon request you may review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.
- 3. Requesting a Restriction on the Use or Disclosure of Your Information:**  
You may request a restriction on the disclosure of your protected health information as described in paragraph one. Vining's Medical Center, P.C. will advise in writing if it agrees to your request as it may interfere with our ability to receive payment from your insurance company. If Vining's Medical Center, P.C. agrees to your request, the restriction will be binding. Thereafter, subject to the terms set forth in the restriction agreement, use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.
- 4. Revocation of Consent:**  
You may revoke this consent; however any such request must be made in writing and is subject the terms and conditions of paragraph three. Any use or disclosure that occurred prior the date on which your revocation of consent is received will not be subject to your requested revocation.
- 5. Reservation of Right to Change Privacy Practices:**  
Vining's Medical Center, P.C. reserves the right to modify its Notice of Privacy Practices from time to time without notice.

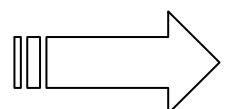
In signing below, I confirm I have reviewed this consent form and give permission to Vining's Medical Center, P.C. to use and disclose my health information in accordance with the terms stated herein.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Today's Date

***On to history form, please***





## New Patient Medical History Form

Your thorough completion of this form is very important as it assists us in understanding your current and historical medical status. If you have any questions when completing this form, please let us know.

### Patient Information

\_\_\_\_\_  
Patient name (Last, First)

\_\_\_\_\_  
Patient date of birth

\_\_\_\_\_  
Today's Date

### Current Prescription Medications

Name of Drug	Dose (i.e., 100mg)	Frequency (i.e., once / day)

Name of Drug	Dosage (i.e., 100mg)	Frequency (i.e., once / day)

### Other Medications (Includes Over-the-counter, Herbs, Supplements, Vitamins, Minerals)

Name of Medication	Dose (i.e., 100mg)	Frequency (i.e., once / day)

Name of Medication	Dosage (i.e., 100mg)	Frequency (i.e., once / day)

### Drug & Food Allergies

I am not allergic to any medications

I am allergic to penicillin  My reaction is: \_\_\_\_\_

I am allergic to sulfa  My reaction is: \_\_\_\_\_

I am allergic to codeine  My reaction is: \_\_\_\_\_

I am allergic to shellfish or iodine  My reaction is: \_\_\_\_\_

I am allergic to latex  My reaction is: \_\_\_\_\_

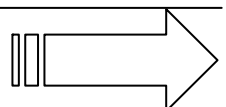
Additional medications I am allergic to:	The reaction I had was:

Foods I am allergic to include:	The reaction I had was:

### Medical Conditions – Indicate if you have (or ever had) any of the following:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Hepatitis or jaundice    | <input type="checkbox"/> Cancer (any type)             |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Liver / pancreas disease | <input type="checkbox"/> Received blood transfusion    |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Kidney stone(s)          | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Other kidney disease     | <input type="checkbox"/> Positive HIV or AIDS          |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Urinary tract infection  | <input type="checkbox"/> Abnormal PAP                  |
| <input type="checkbox"/> Anemia              |  |   |  |

Others (please describe): \_\_\_\_\_



**Surgical History - Indicate if you ever had any of the following (also list the year):**

- Appendix – year:                       Gall bladder – year:                       Thyroid – year:                       Hysterectomy – year:  
 Hernia – year:                       Heart – year:                       Lung – year:                       Spine or any joint – year:  
 Tonsils – year:

Others (please describe): \_\_\_\_\_

**Hospitalizations – List all other than those listed in above surgical history and childbirth:**

Year	Reason

Year	Reason

**Your Social History:**

I drink \_\_\_\_ cups/glasses/cans of caffeinated coffee, tea, or soda per day

Do you smoke now:  yes  no    Smoked in the past:  yes  no

How many years: \_\_\_\_\_    Year quit smoking: \_\_\_\_\_

Other tobacco products I use include:

- None     Cigars     Chewing tobacco     Snuff     Other

Alcohol usage – I drink the following number of drinks per week:

- None     1-7     8-14     14+

Do you participate in recreational drug use:  yes  no

If so, I use: \_\_\_\_\_

My occupation is: \_\_\_\_\_

I have traveled out of the country in the last year:  yes  no

If so, I went to: \_\_\_\_\_

Do you have pets at home?  yes  no

If so, I have:  Dogs     Cats     Birds     Other: \_\_\_\_\_

Do you exercise regularly?  yes  no

Have you signed your driver's license as an organ donor?  yes  no

**Personal Safety (your insurance company requires us to ask these questions):**

I wear my seatbelt:  Always     Often     Occasionally     Never

I have firearms in my home:  yes  no

If so, are they secured?  yes  no

I received my last Tetanus shot on: \_\_\_\_\_

Please note: HIV, the virus that causes AIDS, is spread by blood or sexual contact. If you had multiple sexual partners or used IV drugs presently or in the past, you should consider discussing HIV testing with your health care provider.

**Family History – Check off where applicable (blood relatives only):**

	Living?	Age	High Blood Pressure	Heart Disease	Stroke	High Cholesterol	Diabetes	Any form of cancer	Other (please list)
Father	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	Yes / No	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Any other information you believe we should know:**

**All done...  
Thank you!**