



Patient Registration Form

Today's Date: _____

Last Name: _____

Social Security # _____

First Name: _____ MI: _____

Gender: M ___ F ___

Marital Status: __Single __Married __Widowed __Separated
__Divorced __Other

Date of Birth: _____

Employment Status: __Employed __Unemployed __Disabled __Homemaker __Student __Active Military
__Self-Employed __Other

Race (Optional):

__African-American __Asian __European/Caucasian __Arab __Jewish __Hispanic (non-euro) __Native American
__Multi-Racial __Other

Home Address: _____

Home Phone: (____) _____

City, State, Zip: _____

Cell Phone: (____) _____

Email Address: _____

Work Phone: (____) _____

Work Address: _____

Driver's License #: _____

City, State, Zip: _____

State of License: _____

License: _____

Emergency Contact: _____

Relationship to Patient : _____

Best Phone # for Emergency Contact: _____

Previous Primary Care Physician: _____

Doctor's Phone #: _____

Doctor's Fax #: _____

Dr.'s Address: _____

No Show Policy: (Please initial to confirm that you have read this policy). If I miss an appointment, without calling to cancel at least 6 hours in advance, I agree to pay the required \$25 No Show Fee.

Initial Here: _____

Test Results Phone Call: May we call you to communicate test results to you? ___Y ___N

If yes, which phone numbers can we call? _____

May we leave a message? ___Y ___N

Guarantor Info: Please complete *if guarantor is other than self*. Guarantor is the person financially

responsible for this patient's bill.

Guarantor: _____

Address: _____

City, State, _____
Zip: _____

Employer: _____

Address: _____

City, State, _____
Zip: _____

Driver's Lic. _____
#: _____

State of _____
License _____

Relationship _____
to Pt: _____

Social Security _____
#: _____

Date of Birth: _____

Gender: M ___ F ___

Home Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

E-mail: _____

Insurance Info: If your visit is regarding auto insurance, you'll need to fill out an additional form before being seen.

Please see the front desk to request this form.

Primary _____

Carrier: _____

Address: _____

City, State, _____
Zip: _____

Telephone (____) _____
#: _____

ID #: _____

Group/Plan _____
#: _____

Second _____

Carrier: _____

Address: _____

City, State, _____
Zip: _____

ID#: _____

Group/Plan _____
#: _____

Effective _____
Date: _____

Subscriber's _____
Name: _____

Date of Birth: _____

Gender: M ___ F ___

Relationship _____
to Pt: _____

Social Security _____
#: _____

Effective Date: _____

Telephone #: (____) _____

Subscriber's _____
Name: _____

Date of Birth: _____

Gender: M ___ F ___

Relationship _____
to Pt: _____

Social Security _____
#: _____

Medical History:

Reason for today's visit:

Past and present medical problems:

Past hospitalizations:

Past surgeries:

Past procedures:

Medicines:

Allergies to medicines/foods/environments:

Any history of anaphylaxis (life threatening allergic reaction)? Y N If yes, to what?

Are you a smoker? Y N

How much do you smoke a day? _____

Do you drink? Y N
Daily Y N
?

How much do you drink? Y N

Do you use any illegal substances including marijuana? Y N

What substance(s)? _____

Religious beliefs that affect your health?

Family History:

Father: _____ Mother: _____

Please list major medical issues Siblings: _____

Consents:

A. *Use of photography:* I understand that my photographs may be taken for the purposes of medical treatments or for chart identification purposes at KFM only.

B. *Assignment of benefits/authorization/notice of collection practices:* I request payment of insurance benefits for all services rendered to me or to my child/children to be made on our behalf to KFM. I authorize KFM to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand that I am responsible to pay certain amounts due. These amounts may include annual deductibles, co-payments, and charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action (e.g. late fees, collection agency, court or attorney costs). Please be advised our office may contact you via an automated system regarding appointments

and/or account status. I agree that this authorization shall remain valid unless/until I rescind in writing.

C. *HIPAA Notice of Privacy Practices*: I have read KFM's HIPAA Notice of Privacy Practices and give my consent for KFM to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations.

D. *Payment Policy/Practice Philosophy*: I have read KFM's payment policy and practice philosophy and agree to abide by them.

E. *Email Communication & Patient Portal Services*: I understand that by giving my email address to KFM I may be contacted by email for appointment reminders. When it becomes possible to communicate with KFM via email or via KFM's internet patient portal, I give my permission to give and receive information related to my health through those electronic means.

I certify that I have read and understood the above statements (A-E) and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____

Patient's Agent Representative/Guarantor/Parent Signature: _____ Date: _____

Medicare Consent: (FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to KFM for any services furnished to me by KFM. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

- | | | | |
|--|-----------|---|-----------|
| Is there Medigap coverage secondary to Medicare? | ___Y ___N | Are you or your spouse employed? | ___Y ___N |
| Are you covered under the Black Lung Program? | ___Y ___N | Do you or your spouse have other insurance? | ___Y ___N |
| Are you disabled or have end stage renal disease? | ___Y ___N | Has treatment been authorized by the V.A.? | ___Y ___N |
| Is there insurance coverage primary to Medicare? | ___Y ___N | Is illness/injury the result of an auto accident? | ___Y ___N |
| Is there employer supplemental coverage secondary to Medicare? | ___Y ___N | Did illness/injury occur at work? | ___Y ___N |

I certify that I have read and understood the above statements and have agreed to abide by the terms and conditions.

Patient Name (please print): _____

Patient's Signature: _____ Date: _____

or

Patient's Agent Representative/Guarantor/Parent Signature: _____ Date:
