

PATIENT REGISTRATION

PATIENT DATA

Last Name: _____ First Name: _____ Middle Name: _____
Street Address: _____ Date of Birth: ____/____/____
City: _____ State: _____ Zip: _____
Employer: _____ Job Title: _____
Employer Address: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Email: _____

☐ Check this box if you do NOT want to receive statements and invoices at the email address provided above.

Sex: Male / Female Driver's License #: _____ Soc Sec #: _____ - _____ - _____
Marital Status: _____ Race: _____ Ethnicity: _____
Primary Language: _____ Religious Preference: _____
Relationship to Responsible Party: _____
Preferred Pharmacy: _____ Pharmacy Phone #: (____) _____ - _____

RESPONSIBLE PARTY FOR BILLING PURPOSES (if different from patient)

Last Name: _____ First Name: _____ Middle Name: _____
Street Address: _____ Date of Birth: ____/____/____
City: _____ State: _____ Zip: _____
Employer: _____ Job Title: _____
Employer Address: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Sex: Male / Female Email: _____
Driver's License #: _____ Soc Sec #: _____ - _____ - _____ Marital Status: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Telephone: (____) _____ - _____

INSURANCE INFORMATION

Primary Company: _____ Policy Number: _____ Group Number: _____
Effective Date: ____/____/____ Subscriber: _____ Subscriber Date of Birth: ____/____/____
Secondary Company: _____ Policy Number: _____ Group Number: _____
Effective Date: ____/____/____ Subscriber: _____ Subscriber Date of Birth: ____/____/____
Tertiary Company: _____ Policy Number: _____ Group Number: _____
Effective Date: ____/____/____ Subscriber: _____ Subscriber Date of Birth: ____/____/____

I hereby authorize Dr. Cannon and Dr. Rosedale to furnish information to my insurance carriers and other consulting physicians, hospitals, radiologists, pharmacies, and laboratories for purposes of treatment, diagnosis, payment or health care operations. I assign to Dr. Cannon or Dr. Rosedale all payments for medical services rendered to me or to my dependents. I understand that I am responsible for any amount not covered by my insurances. I understand that payment of any deductibles or co-pays is expected at the time of service unless other arrangements have been made in advance.

Signature: _____ Date: _____

Bring this paperwork to your appointment, or you can email to caritasefaxdocument@gmail.com.

RECEIPT OF *NOTICE OF PRIVACY PRACTICES*
WRITTEN ACKNOWLEDGEMENT FORM

Patient Name: _____ DOB: _____

I have received a copy of Caritas Family Medicine PA's Notice of Privacy Practices.

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* prior to any service being provided to me by the Practice, and I consent to the use and disclosure of my medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

Signature (Patient/Legal Representative): _____ Date: _____

If Legal Representative, relationship to Patient: _____

☐ Patient/Guardian offered *Notice of Privacy Practices*, but declines to accept/acknowledge.

Witness

Date

Name: _____ Date: ____/____/____ DOB: ____/____/____

BIRTH HISTORY

Were there any complications before delivery? Y N Explain: _____

Were there any complications during delivery? Y N Explain: _____

Delivery was: ☐ Full term ☐ Premature ☐ Post dates

☐ Vaginal ☐ C-section

Breast Fed or Bottle Fed or both ? (please circle one)

PAST MEDICAL HISTORY

Please list any chronic problems, hospitalizations or surgeries:

PROBLEM	DATE WHEN FIRST FOUND/NOTED

SOCIAL HISTORY

Current Education Level: ☐ Elementary ☐ High School

Ethnic Background: _____ Religious Preference: _____

HEALTH HABITS

Do you exercise on a regular basis? Y N Type of exercise: _____

How many days per week? _____ How many minutes each time? _____

How many meals per day do you eat? _____ Do you eat breakfast most days? Y N

Do you add salt at the table? Y N About how many calories do you eat each day? _____

How many servings of the following types of food do you eat each day?

Protein: _____ Dairy: _____

Fruit: _____ Vegetables: _____

Grains: _____ Water: _____

Disease	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandfather	Paternal Grandmother	Siblings
High blood pressure							
Heart disease							
Stroke							
Diabetes							
Thyroid disease							
Asthma							
Tuberculosis							
Seizures							
Breast cancer							
Lung cancer							
Colon cancer							
Prostate cancer							
Ovarian cancer							
Other cancer							
Migraine							
Mental illness							
Alcoholism							
Bleeding disorders							
Other major diseases							

MEDICATIONS

Please list any medications to which you are allergic:

MEDICATION	TYPE OF REACTION

Please list ALL medications which you take (including over-the-counter products):

MEDICATION	STRENGTH	HOW OFTEN?	REASON

IMMUNIZATIONS

VACCINE	DATES
DTaP	
HIB	
IPV/OPV	
Hepatitis B	
Hepatitis A	
MMR	
Varicella (chicken pox)	
dT	
Pneumonia	
Influenza	
TB Mantoux	
Meningitis	
Other:	