PATIENT REGISTRATION

CARITAS
FAMILY MEDICINE

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: _____

☐ By checking this box, I consent to receive statements and invoices at the email address I have 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.

CARITAS
FAMILY MEDICINE

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

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

Pediatric Medical History

CARITAS
FAMILY MEDICINE

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

About how many carbohydrates do you eat each day? _____

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:	