REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Birth Date:	Age:	Sex: ☐ M ☐ F	Social Security Number:

Street Address:	Cell phone no.: ( )	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Email:	Race: ☐ Caucasian ☐ African American ☐ Asian	
	Language:	Ethnicity: ☐ Non-Hispanic ☐ Hispanic
Pharmacy name:	Pharmacy location:	Pharmacy Phone #:

Referred to the office by: ☐ Family ☐ Friend ☐ Close to home/work ☐ Ad ☐ Internet ☐ Other: ______________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Member ID:	
Insured Name:		
Relationship to Insured:	Insured Date of Birth:	Insured Soc. Sec. No.:
Secondary Insurance:	Member ID:	
Insured Name:		
Relationship to Insured:	Insured Date of Birth:	Insured Soc. Sec. No.:

NEXT OF KIN

Name of local friend or relative:	Relationship to patient:	Preferred phone no.: ( )

Address of next of kin:	City:	State:	Zip Code:

Mother's maiden name(first and last):

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Medical Home or insurance company to release any information required to process my claims.

_______________________________ _______________

Patient/Guardian Signature *Date*

631-284-3793

I, ________________________________ give permission to discuss my medical treatment and all test results to the people listed on this sheet. I understand that whomever I list below will be given any medical information about me. I also understand that I do not have to choose a person to receive my results and have signed below, accordingly.

Name: _______________________________ Phone: ________________________________

Relationship: __________________________ Phone: ________________________________

Name: _______________________________ Phone: ________________________________

Relationship: __________________________ Phone: ________________________________

Name: _______________________________ Phone: ________________________________

Relationship: __________________________ Phone: ________________________________

Name: _______________________________ Phone: ________________________________

Relationship: __________________________ Phone: ________________________________

____I DO NOT want anyone but me to receive any medical information

Patient Signature: _________________________ Date :__________________________

FINANCIAL POLICY

Thank you for choosing The Medical Home and Dr. Bellamy Brook and his clinicians as your healthcare provider. We are committed to keeping you and your families healthy. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please contact our Practice Administrator if you have any questions at 631-284-3793.

Full payment is due at the time of service. We accept cash, check, and all major credit cards. We reserve the right to charge a $10 monthly billing fee if payment is not made at the time of the service and for any unpaid balances. All patients must complete our "Patient Registration Form" and other related forms. For cases which we bill insurance directly, we must have a copy of the insurance ID card. If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. Please notify us immediately of any changes in your insurance or coverage. 24-hour notice is required for copies of medical records and there may be a nominal fee. We also require 72 hours notice for prescription renewals.

We require 24-hour notice if you are unable to keep your appointment. Failure to do so will result in a $50 no-show fee being added to your account. We will gladly waive this fee for emergencies if you reschedule and complete your appointment within 5 business days.

High Deductible Health Plans. Many plans offered on the healthcare exchange and thru employers now carry high deductibles. This means no payment is made by your insurance carrier until your deductible is met. When your services are applied to the deductible we receive no payment for your care. Therefore payment is expected immediately upon receipt of your first billing statement.

Self-Pay... We expect payment at the time of service unless prior arrangements have been made.

HMO/PPO... All co-payments are due at the time of service. We reserve the right to charge a $10 billing fee if payment is not made at the time of service. We are participating in most insurance plans. You are responsible for verifying in or out of network providers for your plan. If you are an HMO member, you will need to change your primary care physician prior to being seen or we will be unable to see you. Your plan may require a referral. Please call at least 72 hours prior to your appointment with the specialist. PPO patients may be responsible for copays, coinsurance and deductibles. Copays paid at the time of service will be deducted from any additional balances.

Workers' Compensation... If you are here as a result of a work-related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers' Compensation insurance, you are responsible for any charges incurred. If payment is not received from these third parties within 60 days, we have the right to bill you directly.

No Fault/Accident Claims... If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. If payment is not received from these third parties within 30 days, we have the right to bill you directly.

Medicare... We accept Medicare assignment and as a Medicare patient you are responsible for the 20% coinsurance and deductible. If you have supplemental insurance we will bill it directly for you. We must be notified if you choose a Medicare Advantage Plan for your coverage. Your responsibility is based on the plan you choose.

Holter Monitor Agreement... If I require the use of a bolter monitor, I understand and agree to return the monitor within 24-48 hours of placement of the monitor. I also agree to reimburse the office of Dr. Bellamy Brook $2,500.00 if the monitor is lost or damaged.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. My information may be shared with outside sources for the purpose of reimbursement and continuity of care. I understand that I am ultimately responsible for payment for all services. Any unpaid balances can be subjected to a $10 per month billing fee in addition to a 1.5% interest charge.

Printed Name of Patient:____

Signature of Patient or Responsible Party:______________________________ **Date:**__________

Adult Health History Form

Name: ______________________________ ***Date of Birth:*** ________ ***Age:*** ________ ***Today's Date:*** _______

Your answers on this form will help me better understand your medical concerns and history.

How do you rate your overall health? ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

Concern: (Rank by priority)	***Onset***	***Frequency***	***Severity***
Example: Headache	*June 2007*	*4x/week*	*mild/mod/severe*
1.			
2.			
3.			

REVIEW OF SYMPTOMS: *Please check off any symptoms you currently have.*

Constitutional
_____*Recent fevers/sweats*
_____*Unexplained weight loss/gain*
_____*Unexplained fatigue/weakness*

Respiratory
_____*Cough/wheeze*
_____*Coughing blood*
_____*Shortness of breath*

Skin
_____*Rash*
_____*Change in a mole*
_____*Dry skin*

Cardiovascular
_____*Chest pain*
_____*Palpitations*
_____*Leg swelling*

Eyes/Ears/Nose/Throat
_____*Change in vision*
_____*Change in hearing*
_____*Allergies/congestion*
_____*Dry mouth*

Gastrointestinal
_____*Heartburn / reflux*
_____*Blood in stool*
_____*Nausea/vomiting*
_____*Abdominal pain*

Neurological
_____*Headaches*
_____*Memory loss*
_____*Dizziness/Fainting*

Breast
_____*Breast lump*
_____*Discharge*

Genitourinary
_____*Painful/bloody urination*
_____*Sexual concerns*
_____*Leaking urine*
_____*Vaginal/penile discharge*

Psychiatric
_____*Anxiety/Stress*
_____*Sleep problems*
_____*Depression*
_____*Suicidal thoughts*

Blood/Lymphatic
_____*Easy bruising*
_____*Unexplained lumps*
_____*Excess bleeding*

Musculoskeletal
_____*Muscle pain*
_____*Joint pain*
_____*Back pain*

MEDICATIONS: *Prescription, non-presciption, vitamins, supplements, herbs, birth control pills, etc.*

Medication	Dose	x per day	Medication	Dose	x per day
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ALLERGIES or REACTIONS TO MEDICATIONS: *Please list or circle:* ***NO KNOWN ALLERGIES***

Medication	Allergy, Reaction or Side Effect

SURGICAL/TRAUMA HISTORY: *Please list any surgical procedures or traumas with dates.*

Surgery	Date (Year)	Trauma/Injury	Date (Year)

PERSONAL & FAMILY HISTORY: *Please check for personal history & indicate family members.*

Medical Condition	Self	Relative/Spouse	Medical Condition	Self	Relative/Spouse
Alcoholism			Genetic Disease		
Allergies			Glaucoma		
Anemia			Heart Attack		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Birth Defects			Kidney Disease		
Bleeding Disorder			Leukemia/Lymphoma		
Cancer, Breast			Lupus		
Cancer, Colon			Mental Retardation		
Cancer, Lung			Migraines		
Cancer, Melanoma			Nicotine Dependence		
Cancer, Ovary			Osteoporosis		
Cancer, Prostate			Rheumatoid Arthritis		
Cancer, Other (Type)			Stroke		
Depression			Thyroid Disease		
Diabetes			Tuberculosis		
Epilepsy			Other:		

WOMEN'S HEALTH:

# Pregnancies:	# Deliveries:	# Abortions/Miscarriages:
Last Menstrual Period:	Age at 1st Period:	Age at Final Period:

SOCIAL HISTORY: *Please enter the appropriate answer.*

	Type	# Per Day	# Years	Quit Date	Do you want to quit?
Tobacco					Yes No
Alcohol					Yes No
Drugs					Yes No
Caffeine					Yes No

***Weight*:**

Are you happy with your weight? ☐ Yes ☐ No How is your diet/appetite? ________

***Exercise*:**

Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? ________

***Safety*:**

Do you consistently wear a bike helmet? ☐ Yes ☐ No

Do you consistently wear sunscreen? ☐ Yes ☐ No

Do you consistently wear a seatbelt? ☐ Yes ☐ No

Is violence a concern for you? ☐ Yes ☐ No

Have you been abused/threatened? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

Sexual Activity:

Are you sexually active? ☐ Yes ☐ No ☐ In the past but not currently

Do you use birth control? ☐ Yes ☐ No ☐ Birth Control Method: ________

Have you been tested/treated for STDs? ☐ Yes ☐ No

Your sexual partners are: ☐ Male ☐ Female ☐ Both

Socioeconomics:

Marital Status: ☐ *Single* ☐ *Partner/Married* ☐ *Divorced* ☐ *Widowed* ☐ *Engaged*

*Spouse/Partner's Name:*____

Sex & Ages of Children: ____

*Occupation & Employer:*____

*Highest Degree of Education:*____________________________________

*Religious Affiliation:*____

*What are the major stressors in your life?*____________________________

*What do you do to relax?*____

*What are your hobbies/interests?*___________________________________

HEALTH CARE MAINTENANCE: *Please list the dates and results of your last screening tests.*

Screening Test	***Age***	***Date (Year)***	***Results (Normal or Abnormal?)***	
Abdominal Aneurysm	60			N/A
Bone Density (DEXA)	60			N/A
Colonoscopy	50			N/A
Women:				N/A
Mammography	40			N/A
Pap Smear/Pelvic Exam	21			N/A
Men:				N/A
Rectal Exam	40			N/A
PSA	40			N/A

Note: Screening guidelines are based on an individual's risk factors. The above ages are recommendations for a person without increased risk. We may always screen earlier than recommended.

IMMUNIZATIONS: *Please list the dates of your last vaccinations.*

Vaccine	***Date (Year)***	***Adverse Reaction?***
Influenza *(yearly in certain groups)*		
Pneumonia *(once after age 65)*		
Tetanus *(every 10 years)*		
Other		

ADVANCED DIRECTIVES:

Have you signed a Do Not Resuscitate Order? ☐ *Yes* ☐ *No*

Have you created a living will or durable power of attorney for health care? ☐ *Yes* ☐ *No*

Proxy's Name:________________________________ ***Telephone:***____________

Patient Signature: *Date:*

The above history has been reviewed with the patient: ________________________

Bellamy Brook, D.O.

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