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*

THE MEDICAL HOME

Dr.Bellamy Brook

David Berezny, RPA-C MMS

Wendy Gillian Ross, RPAC, AS, BS

Janet Slawinski, NP-C

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 as your health care 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, Visa/Master Card, AmEx and Discover. 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.

UCR (Usual and Customary Rates)... We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of UCR rates.

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

HMO/PPO...All co-payments are due at the time of service. If you do not know your co-pay you may use our telephone to call your insurance provider. 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 or we will be unable to see you. PPO patients will only be responsible for their co-payments and co-insurance as long as they have verified with their insurance that Dr.Bellamy Brook participates in their plan.

Workers' Compensation... .lf you are here as a result of 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, as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 60 days; we have the right to bill you directly.

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 only for the difference between the approved charge and the amount Medicare pays and, of course, your deductible. If you have supplemental insurance we will bill it directly for you. You will receive a bill after your insurance has paid.

Holter Monitor Agreement...If I require use of a holler monitor, I understand and agree to return the Monitor within 24-48 hours of placement of Monitor. I also agree to reimburse the office of Dr. Bellamy Brook $2500.00 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. I understand that I am ultimately responsible for payment for all services.

Printed Name of Patient: _____

Signature of Patient or Responsible Party: _____ **Date:** _____

112014

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) *Example: Headache*	***Onset*** *June 2007*	***Frequency*** *4x/week*	***Severity*** *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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