DOWNTOWN DOCTOR
NEW PATIENT REGISTRATION

Name _____ Preferred or Nickname _____

Gender (needs to match insurancecard) _____ SSN _____ DOB _____ Age _____

Address _____ Unit/Apt. _____

City _____ State _____ Zip _____

Phone (m) _____ (h) _____ (w) _____

Patient Race _____ Ethnicity _____ Marital Status _____

Occupation _____

IN CASE OF EMERGENCY

Who May We Contact? Name _____

Relationship _____ Primary Phone _____ Secondary _____

BILLING INFORMATION

Primary Insurance Carrier _____

Claims Address (back of card) _____ City _____ State _____ Zip _____

Telephone _____ Are you the Primary account holder Y _____ N _____

Guarantor _____ DOB _____ SSN _____

Secondary Insurance Carrier _____

Claims Address (back of card) _____ City _____ State _____ Zip _____

Telephone _____ Are you the Primary account holder Y _____ N _____

Guarantor _____ DOB _____ SSN _____

Patient Signature X _____ Date _____

Whom may we thank for the kind referral? _____

SURGICAL HISTORY

Please list Surgeries and/or hospitalizations you have had and Date: ☐ NONE

_____ _____

_____ _____

_____ _____

MEDICATIONS

Please list any medications, including vitamins and supplements you take. Please include dosage and strength:

☐ NONE

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES

Please list any allergies to medications and type of reaction.

☐ NONE

_____ _____

_____ _____

_____ _____

DO YOU HAVE SEASONAL,ENVIRONMENTAL OR FOOD ALLERGIES?

☐ NONE

_____

SOCIAL HISTORY

Smoker? Y N If "yes" how many cigarettes a day _____ For how long? _____

Chewing Tobacco? Y N If "yes" how often _____ For how long? _____

Do you drink Alcohol? Y N If "yes" how many drinks a week _____

Do you Exercise? Y N If "yes" what type and how often _____

Hobbies _____

Number of Children _____ Ages _____ Work Status _____

PHARMACY INFORMATION

What pharmacy do you use? _____ Phone _____

Do you have a primary care doctor? Y N Would you like to establish care with us? Y N

IMMUNIZATIONS:

Please list dates (year is sufficient) for the following:

Flu_____Pneumonia_____ DTAP(tetanus)_____Hep A/B_____ Guardasil_____ Shingles____

Were you born between 1946-1964? YES OR NO (Hep. C Z72.89) if Quest order HCV Ab reflexes to HCV RNA PCR quant

FAMILY AND PERSONAL HISTORY

Please check any that you or a blood related family member have had and list the family member in space provided

☐ Diabetes_____ ☐ Heart Disease _____ ☐ Cancer _____

☐ Stroke _____ ☐ TB_____ ☐ Glaucoma _____ ☐ Heart Attack _____

☐ Blood Pressure _____ ☐ High Cholesterol _____

PREVENTATIVE CARE

Date last physical exam_____ Date last colonoscopy_____ Date last cholesterol level_____

MALES

Date last prostate exam_____ Date last Prostate Blood Test (PSA)_____ Date last Testosterone level_____

FEMALES

Date last period_____ Age of first period_____ Cycles irregular or regular_____

What form of birth control do you use?_____ Are you satisfied?_____

Date of last Pap_____ Date of last Mammogram_____

Ever had an abnormal pap or mammogram? Details:_____

Date of last Bone Density Test_____

SLEEP

Do you ever doze while doing the following: 0=never 1=slight chance 2=moderate chance 3=high chance

___Sitting and reading ___Watching TV ___Sitting inactive in public place ___Passenger in a car 1hour

___Lying down to rest in afternoon ___Sitting and talking ___In a car stopped for a few minutes

___Sitting quietly after lunch without alcohol ***TOTAL SCORE***_____

Have you ever been told that you snore? Y N Do you have difficulty getting or staying asleep? Y N

REASON FOR YOUR VISIT TODAY:_____

OFFICE POLICIES AND PRIVACY PRACTICES

EMAIL USE

This practice may send you an email notification to you regarding your appointment, bill or general health information. By giving us your email address you consent to use contacting you in this way.

Email Address_____

APPOINTMENT POLICY

Thank you for confidence you have placed in us to care for your medical needs. Your doctor will prescribe an individual treatment plan to care for your condition. This plan will require commitments from both you and your doctor. Once a treatment plan is agreed to, your doctor will need to monitor your progress and may require you to attend visits to our office. In order to ensure availability of time we have establishes a NO SHOW and CANCELLATION policy in our practice.

An appointment is considered NO SHOW when you do not attend a scheduled appointment, arrive 15 or more minutes after your scheduled time, or cancel an appointment with less than 48 hours notice. Due to high demand for appointments we have instituted a $75 fee if you are a NO SHOW to your appointment. Monitoring your health and or condition if very important to the successful outcome of your treatment. It is for this reason that if you NO SHOW for 3 appointments, we will no longer be able to schedule you an appointment time. You will however be eligible to be seen during our walk in hours.

If you have an hour long procedure scheduled and you cancel with less than 48 hours notice you will be billed $225. We ask that if you are unable to make your appointment, you call our office at least 48 hours in advance. This is our CANCELLATION policy and we will make every effort at the time of your cancellation to reschedule you in a slot convenient for both you and the doctor.

PRIVACY PRACTICES

For a detailed description of our HIPAA policies and how your protected health information may be used and disclosed, we encourage you to read and or download our privacy practices prior to signing this consent.

We reserve the right to change and update the notice, we will notify all patients if such a change occurs.

You have the right to request a restriction of the uses and disclosures of your protected health information for the purpose of your treatment and healthcare operations of The Downtown Doctor. We are not required to agree with the restrictions but are bound by any restrictions agreed upon.

<u>Permission to disclose personal health information to family members or others:</u>

Please indicate to whom and what your are willing to disclose below.

Name_____relationship_____DOB_____

May we speak with verbally?__Y__N_____May we release medical records?__Y_____N_____

Name_____relationship_____DOB_____

May we speak with verbally?__Y__N_____May we release medical records?__Y_____N_____

ACKNOWLEDGEMENT:

The Downtown Doctor has the right to refuse to treat you if you do not sign the consent or at anytime you choose to revoke your consent. The Downtown Doctor has the right and is authorized by law to use and or disclose your protected health information in certain circumstances without your consent.

Your signature acknowledges that you have read and understand this consent and our privacy practices. You are also giving authorization to release your medical information to the listed individuals above, if any. And you are aware the you may now or at any time restrict the disclosure of your protected health information.

Patient Printed Name_____Date_____

Signature_____