REGISTRATION FORM (Please Print) Today's date:_____

AFFORDABLE | HEALTH | CARE

PATIENT INFORMATION

Patient's last name: First: Maiden:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Sex: ❑ M ❑ F	Language:	Race: ❑ Caucasian ❑ African American ❑ American Indian ❑ Other_____	Preferred Contact: ❑ Email ❑ Home Phone ❑ Day Phone ❑ Cell Phone	
SSN:	Birth date: / /			
Drivers License # and State:	Mailing Address:		Apt #:	
	City:	State:	Zip Code(To include Last Four):	
Home phone #:	Work phone #:	Cell phone #:	Email:	
Occupation:	Employer:	Employer Phone #: ( )		

INSURANCE INFORMATION

(Please give your insurance card and drivers license to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No ❑ Self Pay

Person responsible for bill:	Birth date: / /	Address (if different):		Home Phone #: ( )	
Occupation:	Employer:	Employer address:		Employer Phone #: ( )	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no: ❑ Other	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 Affordable Health Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

REGISTRATION FORM(Please Print) Today's date:_______

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Medications List – List all medications you take, prescription and non-prescription, and the dosage	
❑ I do not take any medications	
Medication Name	Dosage/Directions

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)	
❑ No Known Allergies	

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
❑ None		❑ Gallbladder Disease	
❑ Allergies		❑ GERD (Reflex)	
❑ Anemia		❑ Hepatitis C	
❑ Angina		❑ Hyperlipidemia	
❑ Anxiety		❑ Hypertension	
❑ Arthritis		❑ Irritable Bowl Disease	
❑ Asthma		❑ Liver Disease	
❑ Atrial Fibrillation		❑ Migraine Headaches	
❑ Benign Prostatic Hypertorphy		❑ Myocardial Infarction	
❑ Blood Clots		❑ Osteoarthritis	
❑ Cancer – Type		❑ Osteoporosis	
❑ Cerebrovascular Accident		❑ Peptic Ulcer Disease	
❑ Coronary Artery Disease		❑ Renal Disease	
❑ COPD (Emphysema)		❑ Seizure Disorder	
❑ Crohn's Disease		❑ Thyroid Disease	
❑ Depression		❑ Other	
❑ Diabetes		❑ Other	

Surgical History – Check if you have received the following procedures, and year performed.			
Exam	Date	Exam	Date
❑ None		Male Only	
❑ Angioplasty		❑ Prostate Biopsy	
❑Angioplasty w /Stent		❑ TURP	
❑ Appendectomy		(Trans-urethral resection of Prostate)	
❑ Arthroscopy Knee		❑ Vasectomy	
❑ Back Surgery		❑ Other	
❑ CABG (Heart Bypass)		❑Other	
❑ Carpal Tunnel Release			
❑ Cataract Extraction		Female Only	
❑ Cholecystectomy		❑ Augmentation Mammoplasty	
❑ Colectomy		❑ Bilateral Tubal Ligation	
❑ Colostomy		❑ Breast Biopsy	
❑ Gastric Bypass		❑ Cesarean Section	
❑ Hernia Repair		❑ D and C	
❑ Hip Replacement		❑ Hysterectomy	
❑ Knee Replacement		❑ Mastectomy	
❑ LASIK		❑ Myomectomy	
❑Liver Biopsy		❑ Reduction Mammoplasty	
❑ Pacemaker		❑ TAH/BSO	
❑ Small Bowel Resection		❑Vaginal Hysterectomy	
❑ Thyroidectomy		❑ Other	
❑ Tonsillectomy		❑Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
❑ None		❑ GYN Exam	
❑ Breast Exam		❑ Influenza Vaccine	
❑ Cardiac Stress Test		❑ Lipid Panel	
❑ Colonoscopy		❑ Mammogram	
❑ DEXA Scan		❑ PAP Test	
❑ Echocardiogram		❑ Physical Exam	
❑ EKG		❑ Pneumococcal Vaccine	
❑ Eye Exam		❑ Pulmonary Function Test	
❑ FOBT (stool card for hidden blood)		❑ Sigmoidoscopy	
❑ Foot Exam		❑ Tetanus Vaccine	

Family History – Check if any family member (s) has had any of the following conditions.

❑Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	❑	❑	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑	❑	❑
Alzheimer's Disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
Blood Disease	❑	❑	❑	❑	❑	❑	❑

Family History - continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
CAD (Heart Attack)	❑	❑	❑	❑	❑	❑	❑
Cancer – Type:	❑	❑	❑	❑	❑	❑	❑
CVA (Stroke)	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Developmental Delay	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	❑	❑	❑
Hearing Deficiency	❑	❑	❑	❑	❑	❑	❑
Hyperlipidemia (High Cholesterol)	❑	❑	❑	❑	❑	❑	❑
Hypertension (High Blood Pressure)	❑	❑	❑	❑	❑	❑	❑
Irritable Bowel Disease	❑	❑	❑	❑	❑	❑	❑
Learning Disability	❑	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑	❑
Obesity	❑	❑	❑	❑	❑	❑	❑
Osteoarthritis	❑	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑	❑
PVD	❑	❑	❑	❑	❑	❑	❑
Renal Disease	❑	❑	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	❑	❑

Social History for Adult Patient

Occupation		Employer	
Do you have children? ❑ Yes ❑ No	How many?	Female (s)	Male (s)
Tobacco Use ❑ No	❑ Daily ❑ Weekly ❑ Less ❑ Former/Year quit:	❑ Chewing ❑ Pipe ❑ Cigar ❑ Cigarette ❑ Smokeless Brand:	
Alcohol Use ❑ No	❑ Daily ❑ Weekly ❑ Less ❑ Former/Year quit:	❑ Beer ❑ Wine ❑ Liquor ❑ Other:	
Exercise Activity	❑ Moderate ❑ Vigorous ❑ Sedentary ❑ Days/Week:	Sleep Pattern: ❑ Changes ❑ No changes	
Caffeine Use ❑ No	❑ Daily ❑ Weekly ❑ Less ❑ Former/Year quit:	❑ Chocolate ❑ Coffee ❑ Soda ❑ Tea ❑ Tablets ❑ Other:	

For Pediatric Patient
❑ Both Parents

Patient Reside with:	Primary	❑ Mother	❑ Father	❑ Other:
	Secondary	❑ Mother	❑ Father	❑ Other:

Mother's Occupation	Father's Occupation
Parents Relationship ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑Widowed	Childcare ❑ Mother ❑ Sibling ❑ Nanny ❑ Father ❑ Grandparent ❑ Daycare
Tobacco Exposure: ❑ Yes ❑ No Smokers at home: ❑ Yes ❑ No	

Please provide the front office with your ID and insurance cards.

Communicating with You

AFFORDABLE | HEALTH | CARE

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office.

We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.

Please check all boxes that you give Affordable Health Care permission to use for your communications:

HOME TELEPHONE: _____ ❑ You may contact me by telephone and leave a detailed message ❑ Leave a message with call- number only	WORK TELEPHONE: _____ ❑ You may contact me by telephone and leave a detailed message ❑ Leave a message with call- number only

WRITTEN COMMUNICATION

❑ O.K. to mail to home address: _____

❑ O.K. to mail to my work/office address: _____

❑ O.K. to fax to this number:_____

❑ O.K. to email to address: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These-provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

AFFORDABLE | HEALTH | CARE

Jennifer Green MSN, APRN, BC

Medical Records Release Authorization

Patient: _____ Date: _____

_____

DOB: _____ SSN: _____

_____

I hereby authorize: _____ to forward copies of the following if at all possible to (843) 757-5546 (Fax)

_____Discharge Summary	_____Lab Reports
_____History and Physical	_____Doctors Orders
_____Operative Reports	_____Progress Notes
_____Consultation Reports	_____Radiology Reports

I understand that the client records are protected under Federal (42 CFR Part 2) and State Confidentiality Regulations and cannot be released or disclosed without written consent. It is understood that this information is not to be released and that this consent expires 90 days subsequent to signing of this release, unless specifically specified for a shorter or longer period of time, not to exceed up to one hundred and eighty days.

Patient Name: _____

Signature: _____Date: _____

Witness:_____Date:_____

AFFORDABLE | HEALTH | CARE

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $85.00 cancellation fee. This also applies for ultrasounds/sonograms as we are billed for the service.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) Date of birth

_____ _____

Signature of Patient or Patient Representative Date