SPECTRUM

Family Medical Clinic, P.A.

JOSEPH M. SACK, M.D.,
JANET JOHNSON, PA-C

7570 W. 21st N., Bldg. 1006A • Wichita, KS 67205 • Phone (316) 462-0460 • Fax (316) 462-0465

PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ DOB: _____ Gender: M or F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____
Social Security #: _____ Employer: _____ Marital status: _____
Race: _____ Primary Language: _____ Secondary Language: _____

Person Responsible for Payment: _____ SSN: _____
DOB: _____ Relation to Patient: _____ Gender: M or F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Employer: _____

Preferred Local Pharmacy: _____ Cross streets: _____

Primary Insurance: _____ I.D. #: _____
Secondary Insurance: _____ I.D. #: _____

Names and Birthdays of Other Family Members Living With You:

Name	DOB	Relationship

Emergency Contact: _____ Relation: _____

Home Phone: _____ Cell phone: _____

Referred by: _____

Patient Signature (or Legal guardian): _____ **Date:** _____

Patient Signature (or Legal guardian): _____ **Date:** _____

Patient Signature (or Legal guardian): _____ **Date:** _____

Patient Signature (or Legal guardian): _____ **Date:** _____

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Patient Name: _____ DOB: _____

SSN: _____

Due to HIPPA regulation we must have your authorization to discuss medical and/or billing information with any person(s) you have authorized. Please list each person you would like us to discuss your medical care with:

_____

_____

_____

_____

_____

Please list each person you would like us to discuss your billing information with:

_____

_____

_____

_____

_____

Please circle yes or no

May we leave test results on your answering machine or voice mail: yes no

May we leave a message with anyone on your test results: yes no

If yes who: _____

May we leave message on your answering machine or voice mail regarding appointment times or reschedules: yes no

May we leave a message with anyone regarding appointment times or reschedules: yes no

If yes who: _____

Patient Signature (or Legal guardian):_____ Date: _____

Patient Signature (or Legal guardian):_____ Date: _____

Patient Signature (or Legal guardian):_____ Date: _____

Patient Signature (or Legal guardian):_____ Date: _____

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HEALTH HISTORY
(ADULT)

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JANET JOHNSON, PA-C

Please fill in the following information about your family health history.

[illegible] • Fax (316) 462-0465

Relation	Age (if living)	State of health (ex: poor, fair, good)	Age at death	Cause of death
Father:				
Mother:				
Siblings:				
M or F				
M or F				
M or F				
M or F				
M or F				
M or F				
M or F				
M or F				
M or F				

Please indicate if any of your blood relatives have had any of the following health concerns.

Disease	(x)	Relation to you
Mental Illness		
Asthma, Hay fever		
Cancer		
Chemical Dependency		
Diabetes		
Heart Disease, Stroke		
AIDS		
Kidney Disease		
Tuberculosis		

Please fill in the following health information about your self.

Hospitalizations Please list any hospitalizations or surgeries you have had (other than pregnancy).

Month/Year	Hospital	Reason

Pregnancy History **(Women Only)** Please fill in the following health information about your self.

Date of your last menstrual period _____ Number of pregnancies you have had _____ Number of live births _____

Number of multiple births (twins, Etc.) _____ Number of miscarriages _____ Number of stillborn _____ Number of abortions _____

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Serious Illness or Injuries

Please list any serious illnesses or injuries you have had.

Have you ever had a blood transfusion? Y or N If so, when? _____

Month/Year	Illness or injuries

Health Habits

Circle your answer

How often have you used any of the following?

Caffeine: Never Occasionally I do Currently I do I have quit. When? _____

Tobacco: Never Occasionally I do Currently I do I have quit. When? _____

Alcohol: Never Occasionally I do Currently I do I have quit. When? _____

Sleeping Pills: Never Occasionally I do Currently I do I have quit. When? _____

Personal Circle your answer

Marital status: Married Divorced Single Widowed Separated

Sexual Practice: Active Inactive Same gender Opposite gender

Sexual Partner: Multiple partner Single partner

Occupational Circle your answer

Are you? Employed Unemployed Disabled Retired

What is your occupation? _____

Do you have any of the following work conditions? High Stress Hazardous Substances Heavy Lifting

Please check all that apply to you in the last 5 years

	General		Mental/Emotional		Neurological		Head and Neck
	Anemia		High Stress		Epilepsy / Seizures		Blindness
	Bleeding Disorder		Trouble Sleeping		Severe Headaches		Partial vision Loss
	Birth Defects		Eating / Dietary Problems		Loss of Memory		Color Blindness
	Severe Allergies		Depression		Stroke		Glaucoma
	Severe Fatigue		Suicide Attempts		Blackouts / Fainting		Cataracts
	Night Sweats		Severe Mood Swings		Coordination Problems		Severe Hearing Loss
	Poor Appetite		Anxiety Attacks		Numbness / Tingling		Severe Dizziness
	Cancer of		Sexual problems		Meningitis		Loss of Smell / Taste
	Diabetes		Alcohol Problems		Brain Tumor		Mouth sores
	Thyroid Problems		Substance Abuse				Lumps in Neck
			Domestic Violence				

Please check all that apply to you in the last 5 years.

	Cardiovascular		Lungs		Intestinal		Bone and Joint
	Heart Attack		Asthma		Stomach Ulcers		Arthritis
	Heart Murmur		Emphysema		Difficulty Swallowing		Gout
	Heart Failure		Tuberculosis		Gallbladder Problems		Torn cartilage
	Chest Pain / Heart Burn		Persistent Cough		Liver Problems		Broken Bones
	High Blood Pressure		Shortness of Breath		Colon Problems		Severe Neck Pain
	High Cholesterol		Pneumonia		Blood in Stool		Severe Back Pain
	Blood Clots / Phlebitis		Coughed up Blood		Weight Loss		Osteoporosis
	Poor Circulation		Pain with Breathing		Hepatitis		Weakness (arms/legs)
	Abnormal Heart Rhythm				Frequent Diarrhea		Joint Replacement
					Chronic Constipation		Amputations
					Chronic Stomach Pain		

	Skin		Infections		Male Only		Female Only
	Eczema		AIDS		Genital Herpes		Genital Herpes
	Psoriasis		HIV Positive		Genital Warts		Genital Warts
	Melanoma		Gonorrhea		Discharge from Penis		Vaginal Infection
	Skin Cancer		Chlamydia		Sores on Penis		Frequent Vaginal Sores
	Hives / Rashes		Syphilis		Painful Testicles		Severe Pelvic Pain
	Severe Sunburn / Burn		Polio		Problem with Erection		Pain with Intercourse
	Use Sunscreen		Measles		Prostate Problems		Breast Problems
	Moles Changed		Rheumatic Fever		Blood in Urine		Problems with Periods
	Hair Loss		Tropical Disease		Kidney Problems		Infertility / Tubule Ligation
			Fungal Infection		Infertility / Vasectomy		Blood in Urine
					Kidney Stones		Frequent Urinary Infection
							Kidney Problems
							Abnormal Pap Smear

Yearly exams Please indicate the month/ year of the following exams. (lines are in front of your choices)

_____ Complete Physical _____ Cholesterol Check _____ Tetanus Shot _____ Eye Exam _____ Dental Exam

_____Colonoscopy (For women only) _____ Pap Smear _____Mammogram _____Dexa Scan

Medications Please list **all** medications you are currently taking. (Prescription & Non-prescription)

Medications	Dosage	Medications	Dosage
1.		11.	
2.		12	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

Please list any medications you are allergic to.

Medication	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Preferred Pharmacy: _____ Location: _____ Phone: _____

Authorization for Pharmacy Medication Lists

I _____ give Spectrum Family Medical Clinic, PA the authorization to contact any pharmacy, whenever necessary, to receive a list of all medications prescribed to me via phone, fax, and/or electronic transmission.

Date: _____

Patient Name: _____

Patient Signature (or legal guardian): _____

Authorization to file Insurance companies

In order to submit a claim with insurance companies for payment to us for services covered under your insurance policy, we must have you authorize to release medical information to you insurance company.

Commercial Insurance

I hereby authorize the release of any information necessary to file a claim with my insurance company and ASSIGN BENEFITS otherwise payable to me to the physician indicated on the claim. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

Medicare Patients only

Name of Beneficiary (self) _____ Medicare # _____ I request that payment of Medicare benefits be made either to me or on my behalf to the above named clinic for any services furnished to me by one of the staff physicians. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agent's information needed to determine these benefits of the related services.

I hereby authorize Medicare to furnish to the above named physician and information regarding and Medicare claims under Title XVIII of the Social Security Act.

Payment Policy

IF ACCOUNT IS TO GO PAST DUE WITHOUT ANY PAYMENT AFTER 60 DAYS, THE ACCOUT WILL BE TRANSFERRED TO A COLLECTION ADJENCY AND A 20% FEE WILL BE APPLIED.

A copy of the signature is as valid as the original.

Patient Signature (or legal guardian): _____ Date: _____

Patient Name: _____

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PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMAITON

DATE: _____

_____ _____
Patient Name DOB

_____ _____
Street Address City State Zip Phone

I request records to be sent from (one previous Doctor or facility): I authorize records to be received by:

_____ _____

_____ _____

_____ _____

The following information may be sent: (please check circle)

- o Complete Health Record
- o Specific type of information (labs, radiology, tests): _____
- o Time period (please specify date range) from date: _____ to date: _____

I understand that this will include information relating to

- ✓ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
- ✓ Psychiatric care
- ✓ Treatment for alcohol and/or drug abuse

Reason For record transfer: _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Spectrum Family Medical Clinic, PA to the above address. I understand this will not apply to any information that has already been released upon my original request. I understand this does not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in thirty (30) days from the date below.

_____ _____
Signature of patient or patients legal guardian Date

_____
Printed name of patient or legal guardian, and relationship to patient

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Date: _____

Patient Name: _____

Patient Signature (or legal guardian): _____

PRESCRIPTIONS

New prescriptions will be written for the patient to deliver to pharmacy or mail to mail-order prescription plan.

Pharmacy may fax in refills if the patient is current on regular med follow up visits and annual physicals related to long-term medication use.

Patient is responsible for authorizing transfers of prescriptions between pharmacies.

Please call the pharmacy for refills - not the office. Allow 24-48 hours for this office to process the refills.

Urine or blood drug screens may be obtained at any time. Inconsistencies or noncompliance may be grounds for immediate dismissal.

Patients need to bring their list of meds or even bring the bottles to help maintain the most accurate records.

When patients want to switch prescriptions for better copays, please bring the list of covered drugs to the scheduled office appointment.

Call the pharmacy to check if refill is ready for pickup, not this office.

Calls received after 4:00pm M-Th or after 11:30 Fri will not be returned till the next business day.

When getting prescriptions requiring follow up visits, please schedule the next appointment before leaving.

We will not:

- Fax prescriptions to mail order plans.
- Refill chronic pain meds without an appointment.
- Call out meds outside of business hours.