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: _____

HEALTH HISTORY

(CHILD)

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

Please fill in the following information about your child's family health history

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				

Please indicate if any of your child's blood relatives have had any of the following health concerns

Disease	(x)	Relation to your child (maternal or paternal)
Asthma, Hayfever, Allergies		
Birth defects or abnormalities		
Cancer		
Chemical Dependency (including Nicotine)		
Diabetes		
Heart Disease, Stroke		
HIV / AIDS		
Kidney Disease		
Mental Illness / Depression		
Seizures / epilepsy		
Tuberculosis		

Please fill in the following health information about your child

Hospitalizations Please list any hospitalizations or surgeries your child has had.

Month/Year	Hospital	Reason

Serious Illness or Injuries Please list any serious illnesses or injuries your child have had.

Month/Year	Illness or injuries

Has your child ever had a blood transfusion? Y or N If so, when? _____

Pregnancy and Birth (infant to age 1 only)

Is the child yours by: Birth _____ Adoption _____ Stepchild_____ Other: _____

Patient Name: _____

Delivery By: Vaginal birth _____ Caesarean _____ If caesarean, why? _____

Where was your child born? _____

Were there any problems during the pregnancy: Y or N If yes please specify: _____

Was your child premature? Y or N if yes, how early: _____

Does your child have any birth defects? _____

Dietary Habits

Has your child had any unusual eating / dietary problems? Y or N If yes, explain: _____

Milk intake now: Nonfat _____ 1% _____ 2% _____ Whole milk _____ Soy milk _____ Rice milk _____ Breast milk _____

Approximate amount (ounces) per day: _____

Please list any foods or beverages your child is allergic to.

Food / Beverage	Reaction

Sleeping Habits

How many hours does your child sleep per night? _____

How many naps does your child take during the day? _____ length _____

Does your child sleep in their own bed? _____

Does your child have any sleeping problems? Y or N if yes, explain: _____

Development

(age 5 and under)At what age did your child toilet train? _____

Has your child had any issues with wetting the bed? Y or N How often? _____ Has it resolved? _____

(Girls only) Date of first menstrual period: _____

Social Habits

Are the child's parents: Married _____ Unmarried _____ Separated _____ Divorced _____

Parent's occupations: Mother _____ Father _____

Who primarily cares for the child: Parents _____ Others _____ (specify who and how often): _____

Daycare / School

Does your child attend: Daycare _____ Preschool _____ School _____

Patient Name: _____

Any concerns about your child's performance in school or daycare? _____

Any concerns about your child's relationships with other children or teachers? _____

Does your child participate in any sports or exercise? Y or N If yes, what activity: _____

Yearly exams Please indicate the month/ year of the following exams.

_____ Well Child Exam _____ Eye Exam _____ Dental Exam _____ Immunizations

Immunizations / Diseases

Has your child had?

Chicken pox: Y or N If yes, when? _____ Measles: Y or N If yes, when? _____

Mumps: Y or N If yes, when? _____ Rubella: Y or N If yes, when? _____

Meningitis: Y or N If yes, when? _____ Tuberculosis (TB): Y or N If yes, when? _____

Has your child ever had a severe immunization reaction? Y or N if so, which immunization? _____

If you child has had any immunizations outside our office please list them below.

Type of Immunization	Date of Immunization	Where was it given

Please check all that apply to your child.

	General		Neurological		Head and Neck		Bone and Joint
	Anemia		Epilepsy / Seizures		Blindness		Torn cartilage
	Bleeding Disorder		Severe Headaches		Partial Vision Loss		Broken Bones
	Poor Appetite		Blackouts / Fainting		Color Blindness		Weakness (arms/legs)
	Cancer of _____		Coordination Problems		Squinting		Amputations
	Diabetes		Brain Tumor		Mouth breathing/ Snoring		Serious sprains

	Cardiovascular		Lungs		Intestinal		Skin
	Heart Murmur		Asthma		Frequent Diarrhea		Eczema
	Blood Clots / Phlebitis		Persistent Cough/ Wheezing		Chronic Constipation		Psoriasis
	Abnormal Heart Rhythm		Shortness of Breath		Chronic Stomach Pain		Severe Sunburn / Burn
	Tires easy with exertion		Pneumonia		Bedwetting		Use Sunscreen
					Pain with urination		Hives / Rashes

	Infections		
	AIDS		Polio
	HIV Positive		Fungal Infection

Does your child currently see any specialist? Y or N if yes, please list:

Specialist Name	Specialty

Medications Please list **all** medications your child is currently taking. (Prescription & Non-prescription) (next page)

Medications	Dosage	Medications	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Please list any medications your child is allergic to.

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

Preferred Pharmacy: _____ Location: _____ Phone: _____

Is there anything else you feel we should know about your child's or your family medical history? _____

_____

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.

Payment Policy

FULL BALANCE IS DUE 60 DAYS AFTER INSURANCE PAYMENT IS RECEIVED. A $10.00 OVERDUE CHARGE WILL BE APPLIED MONTHLY TO ALL ACCOUNTS WITH BALANCES OVER 60 DAYS OLD.

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

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

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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.