Weeks Family Medicine

Registration Form

PATIENT INFORMATION

Last Name:	First:	Middle:	Date of Birth:	Sex: ☐ M ☐ F

Is this your legal name? ☐ Yes ☐ No	Former Name:	Marital Status:	Social Security #
Phone Number:	Email Address:		Ok to Web Enable? ☐ Yes ☐ No
Street Address:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone #
Primary Insurance Name:	Policy #:	Group #:
Secondary Insurance Name:	Policy #	Group #:

Preferred Pharmacy:	Pharmacy Location:
How did you hear about us?	

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ American Indian or Alaska Native	☐ Hispanic	☐ English
☐ Asian	☐ Non-Hispanic/Non-Latino	☐ Spanish
☐ Native Hawaiian, Pacific Islander	☐ Refused	☐ Other
☐ Black or African American		
☐ White or Caucasian		
☐ Other		
☐ Refused		

Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to anyone other than yourself, you must sign this form.

I authorize Weeks Family Medicine to release my medical and/or billing information to the following individual(s):

1.	Relation:	Phone:
2.	Relation:	Phone:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone:

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 Weeks Family Medicine or insurance company to release any information required to process my claims.

_______________________________ Patient/Guardian signature

_______________________________ Date

Weeks Family Medicine Policies

If you are new to Weeks Family Medicine, we welcome you and express our appreciation that you have chosen our office to provide your primary care needs. If you are an established patient, we thank you for continuing to allow us to provide your primary care.

Cancellation of Appointments/No Shows ____ (Initials)

We ask that you provide at least 24 hours advance notice to cancel an appointment. If, due to circumstances not under your control, you are unable to keep your appointment and are also unable to provide at least 24 hours hour notice, please let us know as soon as possible. This allows us to schedule another person is requiring care. Please be advised, we reserve the right to terminate our medical relationship with you if this occurs on more than three occasions.

Behavioral Health Visits ____ (Initials)

Behavioral Health appointments need to be verbally confirmed by the patient. We will start confirmation calls for these visits 48 hours prior to the appointment time. Any patients who have not confirmed with the first reminder call will be given a second call the day before your appointment, if we do not hear from you to confirm, we will cancel your appointment. These types of cancellations will be considered a bad cancel and apply towards our cancellation policy. *(Please see cancellation policy above)*

Prescription Refills ____ (Initials)

Please call your pharmacy regarding refills on medication at 72 hours in advance of needing the medication to allow enough time for the pharmacy and your provider to receive and respond to your request before you run out of the medication. For maintenance medication, your provider will normally provide refills through the pharmacy to last until it is time for your next office visit. If you are out of refills, this may indicate that is it time for you to schedule an appointment with your provider.

Narcotic Prescriptions ____ (Initials)

Lost, stolen or damaged narcotic/controlled substance prescriptions **WILL NOT** be replaced. Therefore, prior arrangements need to be made to ensure pick up of RX's, if you are receiving a prescription for a narcotic or controlled substance you will be required to sign a "Controlled Substance Agreement policy" *(Please see if CSA if interested in more information)*

Telephone Calls ____ (Initials)

Should you have a question or feel the need to speak to your provider by the phone, we are available to answer phone messages during clinic hours, when not providing direct patient care. This is usually at the end of the day. The medical assistant may be asked to return your call after discussing the matter with your provider. Considerable effort is made to respond to phone messages within 24 hours of their receipt, however with a busy clinic schedule, our telephone time is limited. It is preferred that the evaluation of medical problems be conducted during a scheduled office visit. We appreciate your understanding and consideration with this.

Referrals to Specialty Care ____ (Initials)

If your insurance company requires you to have a referral from your PCP prior to seeing a specialist, then they also require your PCP to conduct an evaluation of your medical need for specialty care. Therefore, if you believe you need to see a specialist, we ask that you make an appointment with your provider. If you are currently being seen by a specialist and need your referral renewed, we ask that you notify us of your need at least one week in advance of your appointment with the specialist to allow time to prepare the referral.

Payment Agreement ____ (Initials)

I understand prompt payment for all services is my responsibility and I authorize Weeks Family Medicine to bill my insurance. A monthly statement will be sent to you for any balances. Legal procedures for collection of past due accounts will be initiated if non-payment of accounts extends beyond 120 days and no arrangements have been made. We accept all forms of payment and offer in house payment plans. We are committed to providing care for you and all our fees fall within the acceptable range with insurance companies. Not all services are a covered benefit with all insurance policies, **and it is your responsibility to understand your insurance policy and coverage.**

HEALTH HISTORY QUESTIONNAIRE

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record)

PATIENT INFORMATION				
Last Name:	First:	Middle:	Date of Birth:	Sex: ☐ M ☐ F
Previous provider		Date of last physical exam		

MEDICATIONS		
Name of the Drug	Strength	Frequency Taken

LIST ANY PREVIOUS MEDICAL DIAGNOSIS

ALLERGIES	
Name of drug, food or item	Reaction

SURGERIES		
Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes ☐ No

FAMILY HEALTH HISTORY		
	Age	**Significant Health History**
Father		
Mother		
Siblings	□ M □ F	
	□ M □ F	
	□ M □ F	
	□ M □ F	
Children	□ M □ F	
	□ M □ F	
	□ M □ F	
	□ M □ F	
Grandmother (maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		

HEALTH HABITS AND PERSONAL SAFETY				
EXERCISE	□ Sedentary (No exercise)			
	□ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)			
	□ Occasional vigorous exercise (i.e. work or recreation, less then 4x weekly for 30 min)			
	□ Regular vigorous exercise (i.e. work or recreation 4x weekly or more for 30 min)			
DIET	Are you dieting? □ Yes □ No			
	If yes, are you on a physician prescribed diet? □ Yes □ No			
	# of meals you eat in a day?			
	Rank of salt intake	□ High	□ Medium	□ Low
	Rank of fat intake	□ High	□ Medium	□ Low
CAFFEINE	□ Coffee	□ Tea	□ Cola	□ None
	# of cups/cans per day?			
SEX	Are you sexually active?			
	Do you have sex with Men? Women? Both? (check all that apply) □ Men □ Women			
	How many partners have you had in the last 3 months? One year?			
	Any discomfort with intercourse? □ Yes □ No			
	Illness related to HIV, has become a public health problem. Risk factors for this illness include IV drug use and unprotected sexual intercourse. Would you like to discuss this today? □ Yes □ No			
PERSONAL SAFETY	Do you live alone? □ Yes □ No			
	Do you have frequent falls? □ Yes □ No			
	Do you have vision or hearing loss? □ Yes □ No			
	Do you have an advanced directive and/or living will? □ Yes □ No			
	Would you like information on the preparation of these? □ Yes □ No			
	Physical and/or mental abuse are also a major public health issue. This often takes the form of verbally threatening, sexual or physical abuse. Would you like to discuss this today? □ Yes □ No			

REVIEW OF SYSTEMS (Please circle any that apply)

Neurologic	Allergy	Eyes	Ear/Nose/Throat	Endocrine
Weakness	*Blistering of skin*	*Squinting*	*Frequent runny nose*	*Cold intolerance*
Clumsiness	*Congestion*	*Crossed eyes*	*Mouth breathing*	*Difficulty sleeping*
Balance difficulty	*Sneezing*	*Asymmetric gaze*	*Bad breath*	*Dizziness*
Change in coordination	*Hives*	*Blurred vision*	*Problems with gums/teeth*	*Excessive sweating*
Difficulty speaking	*Itching*	*Diminished visual activity*	*Tugging at ears*	*Excessive thirst*
Dizziness	*Sneezing*	*Flashes of light*	*Blocked ear*	*Frequent urination*
Fainting	*Rash*	*Discharge*	*Decreased hearing*	*Heat intolerance*
Gait abnormality	*Watery eyes*	*Floaters in visual field*	*Decreased sense of smell*	*Weakness*
Headache	*Wheezing*	*Itching and redness*	*Difficulty swallowing*	*Weight loss*
Irritability	*Hay Fever*	*Pain*	*Dry mouth*	Gastrointestinal
Loss of strength	Respiratory	Cardiovascular	*Ear pain*	*Abnormal stomach pain*
Unable to use extremity	*Change in breathing*	*Tire easily*	*Nose bleeds*	*Blood in stool*
Memory loss	*Shortness of breath*	*Fainting*	*Ringing in ears*	*Change in bowel*
Seizures	*Cough*	*Chest pain at rest*	*Sinus pain*	*Constipation*
Tics	*Pain with breathing*	*Chest pain with exertion*	*Sore throat*	*Decreased appetite*
Constitutional	*Sputum production*	*Limping*	*Swollen glands*	*Diarrhea*
Change in appetite	*Wheezing*	*Cyanosis*	Skin	*Difficulty swallowing*
Chills	Breast	*Difficulty lying flat*	*Acne*	*Exposure to Hepatitis*
Fatigue	*Breast Lump*	*Irregular heartbeat*	*Blistering of skin*	*Heartburn*
Night sweats	*Breast Pain*	*Shortness of breath*	*Discoloration*	*Hematemesis*
Weight loss	*Breast swelling*	*Fluid in lungs*	*Dry Skin*	*Nausea*
Sleep disturbance	*Nipple discharge*	Psychiatric	*Eczema*	Rectal Bleeding
Weight gain	*Gland swelling*	*Bad temper*	*Hives*	Musculoskeletal
Weakness	*Red skin*	*Nail biting*	*Itching*	*Muscle pain*
Fever	Genitourinary	*Anxiety*	*Keloid Formation*	*Decreased movement*
Hematology	*Painful urination*	*Hallucinations*	*Moles*	*Carpal tunnel*
Breast lump	*Bed wetting*	*Delusions*	*Nodules*	*Swollen Joints/stiffness*
Dizziness	*Discharge*	*Depressed mood*	*Photosensitivity*	*Leg cramps*
Fever	*Abdominal pain*	*Difficulty sleeping*	*Rash*	*Muscle aches*
Groin mass	*Blood in urine*	*Eating Disorder*	*Scaly lesion*	*Pain in shoulders*
Prolonged bleeding	*Difficulty urinating*	*Loss of appetite*	*Skin cancer*	*Sciatica*
Recent transfusion	*Frequent urination*	*Abuse*	*Skin oozing*	*Trauma to arms*
Swollen glands	*Pain in lower back*	*Suicidal thoughts*	*Sun sensitivity*	*Trauma to knees*
		Substance Abuse		*Trauma to ankles*

Women Only				Men Only			
Irregular periods	*Dysuria*	*Vaginal discharge*	*Breast lump*	Erectile Dysfunction	Testicular Mass	Dysuria	Difficulty with stream
Hot flashes	*bleeding between periods*	*Missing menstruation*	*Discharge from breast*	Blood with urination	Hard Testicle	Hernia	Dribbling
Painful intercourse	*Painful Menstruation*	*Vaginal Itching*	*Irregular menses*	Penile discharge	Scrotal swelling	Rash or blister on penis	Lump in groin