

PATIENT REGISTRATION FORM

Family Medicine Health Center (FMHC) is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.



PATIENT INFORMATION

Last Name:		First Name:		M.I.	Marital Status: (Choose One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er)		
Mailing Address:					Social Security No.:		
City:		State:	ZIP:	Home Phone:		Cell Phone:	
E-Mail:			Employer:		Work Phone:		
Contact for Reminder Calls and Other Electronically Generated Messages: (Choose One) <input type="checkbox"/> Text <input type="checkbox"/> Voice (Select Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work							
Race: (Choose One) <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Alaska Native <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Refused to Report <input type="checkbox"/> Other Pacific Islander		Ethnicity: (Choose One) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Refused to Report		Birth Date: / / MO / DAY / YR Age: Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Unknown	Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female / Male-to-Female <input type="checkbox"/> Transgender Male / Female-to-Male <input type="checkbox"/> Other <input type="checkbox"/> Choose Not to Disclose <input type="checkbox"/> Non-Binary / Gender Queer <input type="checkbox"/> Questioning		Preferred Pronouns: <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Ze/Hir/Hirs <input type="checkbox"/> Ey/Em/Eirs <input type="checkbox"/> Xe/Sem/Xyrs <input type="checkbox"/> Ve/Vir/Vis <input type="checkbox"/> Other <input type="checkbox"/> Patient's Name <input type="checkbox"/> Unknown
Veteran Status: <input type="checkbox"/> Veteran <input type="checkbox"/> Non-Veteran		Preferred Language:					
Family Size (Including Self):		Annual Household Income:			Living Status: <input type="checkbox"/> Own <input type="checkbox"/> Doubling Up <input type="checkbox"/> Rent <input type="checkbox"/> Street <input type="checkbox"/> Public Housing <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other: <input type="checkbox"/> Transitional		
Farmworkers: Has anyone in your household worked in agriculture (fields, orchards, etc.) in the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did that person work for less than 12 months out of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did that person move from place to place for work? <input type="checkbox"/> Yes <input type="checkbox"/> No Is anyone in your household a retired farmworker? <input type="checkbox"/> Yes <input type="checkbox"/> No							

For each statement, please tell me whether the statement was "often true, sometimes true, or never true" for your household:
 Within the past 12 months, we worried whether our food would run out before we got money to buy more. Often True Sometimes True Never True Don't Know, or Refused
 Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. Often True Sometimes True Never True Don't Know, or Refused

RESPONSIBLE PARTY

Person Responsible:		Birth Date: / /	Address (if different):		Home Phone:
Occupation:	Employer:	Employer Address:		Employer Phone:	
Is this person a patient of FMHC? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is this patient covered by Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		

INSURANCE INFORMATION (Please give your insurance card to the Receptionist)

Name of Primary Insurance: <input type="checkbox"/> IPN <input type="checkbox"/> Tricare <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other:					
Primary Medical Insurance			Secondary Medical Insurance		
Subscriber's Name:	Subscriber's SSN:	Birth Date: / /	Subscriber's Name:	Subscriber's SSN:	Birth Date: / /
Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Parent <input type="checkbox"/> Other			Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Parent <input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address):	Relationship to Patient:	Phone Number:	Alternate Phone Number:
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NOTE: MEDICARE SECONDARY RECIPIENTS NEED TO COMPLETE THE NEXT SECTION

- Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
- Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- Medicare Secondary, Other Liability Insurance is Primary
- Medicare Secondary, No-fault Insurance including Auto is Primary
- Medicare Secondary Worker's Compensation
- Medicare Secondary Veteran's Administration
- Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
- Medicare Secondary Public Health Service (PHS) or Other Federal Agency
- Medicare Secondary Black Lung

FOR FMHC STAFF USE ONLY

If the patient or guardian refuses to sign/complete this form, please complete this section. Date offered to patient: / / FMHC Staff Initials:

Consent for Outpatient Treatment

This form includes important information about how care is provided to patients at Family Medicine Health Center (“Health Center”). Patients and parents, guardians, and other patient representatives should read this information carefully or ask for assistance to have the form read to you. By signing this form, you agree to receive care at the Health Center according to the following terms and conditions:

1. **Consent.** I request and authorize the Health Center and its physicians, residents, assistants and designees to provide the medical care and treatment necessary or advisable to me, or the patient identified below. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care.
2. **Emergencies.** I authorize the Health Center to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my, or the patient’s, life or health.
3. **Risks and Benefits.** I am aware that the practice of medicine is not an exact science and I understand that the Health Center is not making any guarantees or promises about the results of the care received.
4. **Health Changes.** I understand that it is my responsibility to tell the Health Center if there are any significant change in my, or the patient’s, physical or emotional condition.
5. **Testing.** I understand that samples of body fluids and/or tissues may be withdrawn during tests and procedures. I authorize the Health Center and its affiliates to perform other tests on these body fluids and/or tissues in order to further treatment.
6. **Medication Verification.** I authorize the Health Center to contact healthcare providers from whom I, or the patient, have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies (i.e. Walgreens, CVS, Costco, etc.), and alcohol and other drug treatment records for verification of my medications and treatment.
7. **Transmittable Diseases.** I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis Bvirus) tests may be performed on me, or the patient, without my consent if a health professional, facility employee or First Responder sustains an exposure to my, or the patient’s, blood or other body fluid.
8. **Personal Valuables.** I understand that I am responsible for any and all personal valuables that I bring with me, or the patient, to the Health Center. I hereby release the Health Center and its agents from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my, or the patient’s, care and treatment.
9. **Residency Program.** The Health Center is operated by the Family Medicine Residency of Idaho. Health Center patients are cared for by a medical team that includes a physician, a resident and a mid-level provider (PA, NP, and CNM). The physician and resident will be your primary providers. A resident “is a doctor who has received a medical degree (MD, DO) from an accredited medical school and who practices medicine under the supervision of a fully licensed physician, usually in a hospital or clinic”. I consent to having a resident and student involved in my, or the patient’s, care.
10. **Acknowledgement of Privacy Practices.** The Health Center’s Notice of Privacy Practices provides information about how protected health information about patients may be used or disclosed for purposes of treatment, payment or the Health Center’s operations. Information about communicable diseases and infections, including venereal disease, tuberculosis, hepatitis B, HIV (AIDS virus) and AIDS related complex, alcohol and drug abuse treatment information, mental health treatment records, and reports of abuse, abandonment or neglect may be used and disclosed under certain circumstances. I have been offered an opportunity to review the Notice before signing this

Consent for Outpatient Treatment

consent. I understand that the terms of the Privacy Notice may change and that I may request a current copy from the Health Center at any time.

11. Attendance Policy. A copy of the Health Center's Attendance Policy has been made available to me. I understand it is my responsibility to know my, or the patient's, appointment dates and times and I understand that services may be discontinued in the event I, or the patient, do not attend scheduled appointments.
12. Ending Treatment. I understand that I have the right to terminate treatment at the Health Center at any time I choose to do.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

Signature of Patient/Legal Guardian

Date

Authorization to Bill Insurance, Financial Responsibility, Credit Policy

Authorization to Bill Insurance and Assignment of Benefits. The patient information is true to the best of my knowledge. I authorize FMHC to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to FMHC. I understand that I am financially responsible for any balance. I also authorize Family Medicine Health Center or insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

Financial Responsibility. I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Family Medicine Health Center, including charges that are not paid in full by my insurance, government program benefits, or other third-party payers. I also agree to pay or reimburse FMHC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. Services provided by outside companies, (i.e., lab, pathology, radiology, durable supplies) are billed separately by those companies.

Credit Policy

PHILOSOPHY: It is the desire of Family Medicine Health Center (FMHC) to provide quality medical and behavioral health services without barriers to access. This policy guides us in providing access to care while also ensuring we collect amounts owed to us for the provision of services. For those patients with insurance coverage, we will properly bill insurance on a timely basis. If you do not have insurance coverage, we are sensitive to your financial constraints and do not want to impede access to care that is vital to your health. FMHC will work with its patients on payment plans to absolve account balances but requires that the patient stay engaged in this process and follows the terms that have been agreed to.

PROCEDURE:

1. We will request payment at the time of service. If you are unable to pay the adjusted amount due at the time of appointment, we will ask that you pay what you can and FMHC will bill you the balance.
2. If you receive an account statement from us and cannot pay the entire balance, we request that you contact us within 30 days about a satisfactory payment plan to resolve the amounts due.
3. If you have not made any payments on your account and have not agreed to a payment plan to resolve the balance within 30 days, you will receive a notice that your account may be referred to an outside collection agency.
4. If you have not attempted to resolve your account with payment nor communicate with us regarding a payment plan, a final notification will be sent to your last known address informing you that your account is being referred to an outside collection agency. At the time your account is listed with the collection agency, your credit record may be adversely affected.

It is the experience of Family Medicine Health Center that the vast majority of our patients understand and cooperates with our long standing credit policy. Family Medicine Health Center is disclosing our policy to you now, so that we may avoid any misunderstanding in the future. By signing you acknowledge that you have read, understand and agree to comply with this credit policy.

Signature of Patient/Legal Guardian

Date

Medicare/Medigap Authorization

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Family Medicine Health Center for any services furnished me by FMHC. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Legal Guardian

Date



FAMILY MEDICINE HEALTH CENTER

New Patient History Form

Legal name: _____

Preferred name: _____

DOB: _____

Thank you for taking the time to complete this form. If you have entered any of this information into your Mychart you do not need to relist.

Please list all current health issues:

- _____
- _____
- _____
- _____
- _____
- _____

Please list all current medications with doses and frequencies (include over the counter medications and natural remedies):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please list all Allergies:

- _____
- _____
- _____

Please list all surgeries and years in which they occurred:

- _____
- _____
- _____
- _____
- _____

Family History (check all that apply):

Relationship	Alcohol/drug use	Arthritis	Asthma	Cancer (Type?)	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Mental Illness	Stroke	Vision Issues	Other _____
Mother															
Father															
Sister															
Brother															
Daughter															
Son															
Maternal Aunt															
Paternal Aunt															
Maternal Uncle															
Paternal Uncle															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															
Other															

I am adopted I don't know my family history

Habits:

Do you smoke? Never Previously Current **Use smokeless tobacco or vape?** Yes No
 Quit Date: _____ Pack/day: _____ Years smoked: _____

Do you drink alcohol? Never Previously Current
 How often do you drink? Less than once/mo 2-4x/mo 2-3x/week Most days
 How many drinks do you have on a day you are drinking: _____

Do you use drugs? Never Previously Current **Have you ever injected drugs?** Yes No
 Type of drug(s) used:
 Benzodiazepines Ecstasy Cocaine Heroin Marijuana Methamphetamine Opioids

Are you currently sexually active? Yes Not right now Never
 Are you and your partner(s) using a birth control method? Yes No
 If yes, circle all that apply: Condoms Pill Patch Vaginal ring Depo injection IUD Nexplanon
 Spermicide Withdrawal Tubal ligation Vasectomy
 What types of partners do you have: Male Female Both

Pregnancy History: This does not apply to me
 How many pregnancies have you had? _____ How many deliveries? _____