United Doctors
Family Medical Center

2986 US HWY 431 Boaz, Al 35957
Office: 256-840-8181 Fax: 256-744-8282

PATIENT REGISTRATION

☐ NEW PATIENT ☐ EXISTING PATIENT

PATIENT INFORMATION

TODAY'S DATE: ____/____/_____

NAME: _____
LAST FIRST MIDDLE Suffix (Jr, III, etc.) PREFERRED "NAME"

GENDER: ☐ MALE ☐ FEMALE AGE: _____ DATE OF BIRTH: ___/___/____ Social Security Number : _____-_____-_____

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____WORK: (_____) _____-_____

MAILING ADDRESS: _____APT. #_____

CITY_____STATE_____ZIP_____

PHARMACY NAME: _____ PHARMACY PHONE: (_____) _____-_____

PHARMACY LOCATION: (SHOPPING CENTER, STREET, CITY, STATE) _____

DRIVERS LICENSE #: _____ STATE: _____ EMPLOYER: _____
DO YOU WANT TO RECEIVE APPOINTMENT REMINDERS VIA AUTOMATED TEXT MESSAGE? ☐ YES ☐ NO
EMAIL: _____

MARITAL STATUS:
☐ RIED
☐ SINGLE
☐ DIVORCED
☐ WIDOWED
☐ COHABITATE

RACE/ETHNICITY:
☐ AMERICAN INDIAN/ALASKA NATIVE ☐ OTHER
☐ ASIAN ☐ DECLINE
☐ BLACK/ AFRICAN AMERICAN
☐ HISPANIC/ LATINO
☐ NATIVE AMERICAN/OTHER PACIFIC ISLANDER
☐ WHITE/ CAUCASIAN

PRIMARY LANGUAGE:
☐ ENGLISH
☐ OTHER: _____

EMERGENCY CONTACT:
Name: _____ Relationship: _____Phone:_____
Name: _____ Relationship: _____Phone: _____

IF PATIENT IS A MINOR, PROVIDE PARENT AND/OR LEGAL GUARDIAN'S INFORMATION:
Full Name: _____ Relationship: _____DOB: _____/_____/_____
Address: _____City:_____State:_____Zip:_____Phone: _____
Full Name: _____ Relationship: _____DOB: _____/_____/_____
Address: _____City:_____State:_____Zip:_____Phone: _____

INSURANCE INFORMATION:
Please present and provide all copies of insurance cards to the receptionist at time of visit to be copied. If you cannot provide your insurance cards, your insurance cannot be verified and you may be responsible for payment for your visit and services rendered.

PRIMARY INSURANCE: _____Subscriber's DOB: _____/_____/_____
Subscriber Name: _____Contract #:_____Group#: _____
Effective Date: _____/_____/_____ Subscriber Social Security #: _____-_____-_____ Relationship to Patient: _____
Subscriber Employer: _____

SECONDARY INSURANCE: _____Subscriber's DOB: _____/_____/_____
Subscriber Name: _____Contract #:_____Group#: _____
Effective Date: _____/_____/_____ Subscriber Social Security #: _____-_____-_____ Relationship to Patient: _____
Subscriber Employer: _____

I, the undersigned, have read and reviewed the above information and following releases and I have executed this instrument voluntarily.
Signature of Responsible Party_____ Relationship to Patient: _____Date: ____/____/_____
Signature of UDFMC witness: _____Date: ____/____/_____

CONDTIONS OF REGISTRATION AND TREATMENT

UDFMC PRACTICE

United Doctors Family Medical Center, LLC and/ or its employees, physicians, nurse practitioners, agents, or assignees will hereafter be referred to as "UDFMC Practice".

CONSENT FOR TREATMENT

The undersigned patient or responsible party for patient consent to the administration of medical treatment, diagnostic and/or therapeutic procedures and minor surgical intervention as required by the healthcare provider rendering care to the patient or the child(ren) of the responsible party. Procedures may include, but are not limited to, minor surgical procedures, x-ray, lab, and/or ultrasound.

HIV/HEPATITIS B & C TESTING NOTIFICATION

In accordance with Alabama State Law, any patient whose blood and/or body fluids that a healthcare worker has been exposed to, will be deemed to consent for HIV/Hepatitis B & C testing. In all other cases, the patient shall have the right to be informed of consent or refusal for HIV/ Hepatitis B & C testing.

INSURANCE BENEFITS AUTHORIZATION AND ASSIGNEMENT

The undersigned patient or responsible party for patient hereby authorizes UDFMC Practice to apply for benefits for services rendered to patient or child(ren) under the terms of any insurance policies or programs providing benefits and do hereby also assign and authorize payment of benefits from insurance company to UDFMC Practice. By signing below, patient or responsible party, hereby authorizes UDFMC Practice to contact the employer or insurance company regarding insurance information, existence of insurance and benefit coverage. Patient or responsible party understands and is responsible for the medical charges not covered by (prior) authorization.

REFERRALS AND AUTHORIZATIONS

Patient or responsible party understands and is notified it is their personal responsibility, if the subscriber's insurance requires any prior referrals, pre-certifications, or prior authorizations to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorizations from UDFMC Practice or insurance company prior to such non-emergency services being rendered. Patient or responsible party must also notify UDFMC Practice prior to going, if possible, or within (48) hours, or in accordance with the insurance company's requirements, of any emergency room visit. If any previous procedures are not done, the patient or responsible party understands that this may cause reduced or rejected coverage for which the patient or responsible party will be responsible. Additionally, the previous actions do not guarantee the insurance company will pay for services rendered and patient or responsible party may still be responsible for claims. Any denial of claims is between the policy holder/subscriber and their insurance company. Patient or responsible party agrees to notify UDFMC Practice immediately of any changes in insurance and/or benefits, or change of personal information.

FINANCIAL AGREEMENT

UDFMC Practice will accept payment and file insurance benefit claims per UDFMC Practice contractual agreements with participating insurance companies. Insurance questions, or disputes, concerning insurance coverage or payment of benefits is a matter between the insurance policyholder/subscriber and the insurance company. Assistance with this by UDFMC Practice is strictly as a courtesy and implies no responsibility on UDFMC Practice's part for filing, follow through for confirmation, or guarantee of payment by the insurance company.As consideration for UDFMC Practice rendering service to the patient, the patient or responsible party agrees to pay all charges for services rendered at the time of such services. Patient co-pay and deductible must be satisfied prior to medical care visit and all balances are due at the time of check out. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, failure to add a dependent to the insurance plan, non-payment at the time of service, or any other reason, patient or responsible party agrees to pay all balances within (30) days of services rendered. If payment is not received within (30) days, UDFMC Practice, will make reasonable efforts to collect, then, at its discretion, may place the unpaid balance with a collection agency and/or attorney. The patient or responsible party for the account agrees to pay a reasonable collection fee, attorney fee, court cost, and any other cost of collection proceedings.

Patient or responsible party understands a bill may be received separately for services rendered by other professionals, including but not limited to, to the reference lab (Marshall Medical Center South), or any other entity identified at time of testing.

Patient or responsible party agree to payment of the following fees, when applicable: Simple form completion $15; Complex form completion $50; Medical Records pages 1-25 $1 per page and then $.25 for each additional page after first 25; Missed special procedure scheduled appointment $25; Returned check fee: $35 (or allowable by District Attorney); 5% late fee on account balance, assessed every (28) days, any additional fees posted. Patient or responsible party understands these fees will be a personal financial responsibility and not sent to the insurance company.

If any insurance company requires a patient to select a PCP (Primary Care Physician) and patient has not selected UDFMC Practice or one of its providers, or has not obtained the proper referral from assigned PCP, patient or responsible party agrees to be 100% financially responsible for incurred charges.

COPY OF SIGNATURE

Patient or responsible party permits a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic, or telephonic for the purpose of payment, treatment or operation.

CERTIFICATION

I certify that the information I have reported with regard to my insurance coverage is correct and the above be honored by my insurance carriers.

I certify that I have read and understand the above information to the best of my knowledge and what I have reported is correct. As the patient/parent/guardian/guarantor, I have read, accept, and understand the terms and conditions of this registration and treatment as stated on this document

Signature: _____Relationship to Patient: _____ Date: _____/_____/_____

Printed Name: _____

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PATIENT MEDICAL HISTORY

NAME: _____ DOB: _____/____/_____ TODAY'S DATE: _____/____/_____
LAST FIRST MIDDLE INITIAL

THE FOLLOWING INFORMATION WILL BE PART OF YOUR PERMANENT MEDICAL RECORD.
PLEASE COMPLETE AS ACCURATE AS POSSIBLE.

ALLERGIES: Please list any medication, food, environmental or other allergy and the type of reaction you experience:

_____

_____

Have you traveled outside of the country or been in contact with anyone who has traveled outside of the country in the past (21) days?
☐ YES ☐ NO

Female: (Menstrual History) Date of Last Menstrual Cycle: _____ ☐ Regular periods ☐ Irregular periods ☐ pause
Date of Last Pap Smear: _____ Date of Last Mammogram: _____
Date of Last Colonoscopy: _____

MEDICATIONS

List all medications taken on a regular basis and all over-the-counter (non-prescription) medications used more than once a month. Please specify the name of the medication, the amount and dose of each pill and the frequency in which each pill is taken. Please list any problems or side effects, if any, that is experienced with any of the listed medications. (Example: "itching", "upset stomach"," headache", etc.").

MEDICATION	DOSE	FREQUENCY	PROBLEM		MEDICATION	DOSE	FREQUENCY	PROBLEM

DO YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING and/or SYMPTOMS:

Cardiorespiratory
☐ ness of Breath
☐ Blood Pressure
☐ t Pain
☐ ezing
☐ ng spells
☐ Foot / ankle swelling
☐ Pacemaker/Defibrillator
☐ COPD
☐ CHF
☐ hrombosis/Blood Clot
☐ Sleep Apnea

Gastrointestinal
Los ☐ ppetite
Gas ☐ ypass/ Lap Band
☐ sea/ Vomiting
Acid Reflu ☐ cers
Rectal B ☐ ng
☐ Change in bowel habits
☐ Pain
☐ Acid Reflux

Genitourinary
Painful urina ☐
Blood in urin ☐
Menstrual ☐ ems
Bo ☐ Joint Jaundice
Infection ☐
☐ Stones
☐ Prostate problems
☐ Frequent urination

Nervous System
Conv ulsions/S ☐ e
Paralysis ☐
Stro ☐

Endocrine System
Thyroid ☐
Diabetes ☐
Live ☐ lems ☐
☐ Arthritis
☐ Osteoporosis
☐ Joint Replacement

Skin
☐ Psoriasis
☐ EczemaTuberculosis

Other
☐ STD
☐
☐ Hepatitis
__A __B __C
☐

Other: _____ ☐

List any past OR SCHEDULED surgeries. Include dates of surgery if known.

SURGERIES	DATE	COMPLICATIONS

SOCIAL HISTORY

Do you use any of the following products? If yes, please complete additional information.

☐ Tobacco- Type: _____ Amount per day: _____ # Years of Use: _____

☐ Alcohol - Type: _____ Amount per day: _____ # Years of Use: _____

☐ Illegal Drugs – Type: _____ Amount per day: _____ # Years of Use: _____

☐ Habits: Frequency of exercise/physical activity: ☐ Daily ☐ Weekly ☐ Monthly ☐ Unable

FAMILY MEDICAL HISTORY

Please complete as accurately as possible. This will be updated each visit and placed in your permanent medical record.

Family Member	Health Status	Diabetes	Heart Disease/condition	Cancer	Lung Disease	Arthritis	Mental Illness	Stroke	Other	If deceased, cause of death & date
Example	Good Fair Poor		heart attack 2011		COPD				Anemia	
Patient										
Mother										
Father										
Sibling										
Grandparents (Maternal)										
Grandparents (paternal)										
Child										

Immunization Record: Please complete this portion as fully as possible. If the patient is a child and a copy of their immunization card is available, please bring the card to the receptionist with the insurance card to be copied.

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Tetanus Toxoid DTP-DT / Td /Hib								
OPV "Polio"								
TB Skin Test (PPD)								
MMR								
Varicella								
Influenza								
Pneumovac								

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Gamma Globulin								
Chicken Pox Vaccine								
Hepatitis "B"								
Hepatitis "A"								

****Do you have an Advanced Directive** ☐ Yes ☐ No If no, Do you want information? ☐ Yes ☐ No

I have completed the medical and family history form to the best of my knowledge as accurately as possible. I am aware this will become part of my permanent medical record.

_____ _____ _____ _____

Patient Signature / Responsible Party **Date** **UDFMC Authorized Staff/Triage** **Date**

UDFMC Authorized Staff Review. I have reviewed the medical and family history for the above patient for the following dates:

DATE	INITIALS		DATE	INITIALS		DATE	INITIALS		DATE	INITIALS