Hawthorne Family Medicine

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www.hawthornemedicine.com

Patient Registration Form

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	PRIMARY CARE PHYSICIAN

MAIDEN NAME	NAME YOU GO BY	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

STREET ADDRESS	APT. NO.

CITY	STATE	ZIP	HOME PHONE

SOCIAL SECURITY NUMBER	AGE	GENDER ☐ Male ☐ Female	CELL PHONE

EMPLOYER	OCCUPATION	Email

EMERGENCY CONTACT / RELATION TO PATIENT	EMERGENCY CONTACT PHONE

SPOUSE OR PARENT / RESPONSIBLE PARTY INFORMATION

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT ☐ Parent ☐ Legal guardian ☐ Other _____

STREET ADDRESS	APT. NO.	HOME PHONE

CITY	STATE	ZIP	CELL PHONE

SOCIAL SECURITY NO.	DATE OF BIRTH

How did you hear about us?

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY	COPAY	EFFECTIVE DATE

ID (POLICY NO.)	GROUP NO.

SUBSCRIBER	RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S SOCIAL SECURITY NO.

***M*otor *V*ehicle *A*ccident Information *Only*:**

Date of accident: ____/____/_____ Claim Number: _____

Insurance Co. Assigned to your claim: _____

Claims Address: _____ City/State: _____ Zip: _____

Claim Agents Name: _____ Phone Number: (____) _____

***Insurance Payment Authorization and Release*:**

I hereby authorize my insurance benefits to be paid directly to *Hawthorne Family Medicine* and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information requested by my insurance company.

Authorized signature _____ ***Date*** _____

Hawthorne Family Medicine

ACKNOWLEDGMENT AND CONSENT

I understand that **Hawthorne Family Medicine** (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)
Description of Representative's Authority:_____

Hawthorne Family Medicine Policies

Thank you for selecting HFM for your primary care provider. Our scheduling, credit & billing policies are provided below for your convenience and reference

Scheduling Appointments:
New patients are asked to arrive 15-20 minutes before your scheduled appointments in order to fill out new patient forms. Please have your driver's license/photo ID and insurance card when arriving.
We require ALL patients to show a photo I.D. at every visit to protect YOU from Medical Identity Theft. Medical Identity Theft occurs when someone uses another person's identity to falsely obtain health care benefits. The result can be medically and financially devastating to the victim.

Please choose a time for your appointment that you can keep. Our extended office hours are:

Mon/Tues/Thurs	8:30am - 5pm
Wednesday	8:00am - 2pm
Friday	9:00am - 4pm
**Lunch break	12:30pm-1:30pm

Our goal is to meet your family's needs in a caring *and* efficient manner. We value your time and will make every effort to accommodate you as soon as possible.

Cancellations/Rescheduling:
As a courtesy, please phone at least one day in advance if you will not be able to keep your appointment. We will do our best to coordinate another appointment for you, if necessary.

Missed Appointments:
A missed appointment is costly for everyone. Patients who fail to keep appointments will be **billed $25** for the missed appointment.
A "No-Show' appointment is recorded when a patient does not show up within 10 minutes of the scheduled appointment. When a patient *misses **3** appointments*, we will regrettably have to request that the patient seek the medical services of another health provider.

Credit and Billing Policies:
Payment for services, including applicable *co-payments*, are due at the time of your visit and will be collected on the day that you see the doctor. We accept cash, checks, Visa and MasterCard. Unpaid charges are billed to you on a bi-monthly statement and are due upon receipt. If you need to make arrangements for a payment plan, please call and speak directly to our billing specialist at **503.963.9181 (ext 5)**
We will make every effort to work out a mutually satisfactory payment schedule.

****As part of continuing medical education, *Dr. Bryan Walls* and *Sarah Brown P.A.-C* occasionally have students and residents working with them. Please initial if they have your permission to participate in your care.** _____
(initial)

Once again, thank you for choosing Hawthorne Family Medicine for your health care needs. We are pleased to have you as our patient.

I have read the above policies and understand the terms and policies of Hawthorne Family Medicine:

Signature _____ ***Date*** _____

New Patient History

Date: _____

Have you ever had or do you currently have any of the following--Please circle all that apply and briefly explain:

- Significant weight change (up or down) fatigue, fever, chills, or night sweats _____
- Problems with your eyes, ears, nose, throat _____
- Chest pains, high blood pressure, heart trouble, palpitations, irregular heart beat _____
- Shortness of breath, cough, wheezing, asthma, tuberculosis, or emphysema _____
- Problems of the stomach, intestines, liver or gall bladder _____
- Problems with your bladder, kidneys, painful urination, discharge, blood in your urine, decreased libido or impotence, history of sexually transmitted disease _____
- Problems with your back, spine, joint pains or swelling, muscle cramps, arthritis _____
- Problems with your skin, including itchy dryness, psoriasis, other _____
- Dizziness, fainting, seizures, numbness, weakness, history of tremors _____
- Psychotic illness, depression, suicidal, anxiety, moodiness _____
- History of physical or sexual abuse _____
- Diabetes, thyroid, or other endocrine problems _____
- Abnormal bruising, bleeding, anemia, or enlarged lymph nodes _____
- Allergies, hay fever, or persistent infections _____
- Any other past of present medical problems not listed above? _____
- Any surgeries or hospitalizations? _____
- Please list all **medications** you have been taking over the ***past year*** (including herbs, supplements, and over the counter medications:

  _____
  _____
  _____
  _____
- Please list any drugs you have had an *allergic reaction* to and *explain* what the reaction was:

  _____
- Are you currently using tobacco products? **YES** **NO** How much & how often: _____
- Have you *ever* used tobacco in the past? **Cigarettes, Cigars, Chew** For how long? _____
- Do you **or** have you ever consumed alcoholic beverages? **YES** **NO**
- If yes, how much do/did you use on average? _____ For how long? _____
- Do you drink coffee or other caffeinated beverages (including soda and tea)? **YES** **NO**
- If yes, how many cups/ounces per day? _____
- Do you now, or have you *ever* used street drugs? **YES** **NO** (*Please circle any you *still use*, even occasionally)
  Heroin Meth Mushrooms Cocaine Pot other : _____
- Please list any family history of medical problems (such as high blood pressure, diabetes, cancer, heart disease, etc)

  _____
  _____
  _____

- Liver Disease/ Hepatitis Risk: **YES** **NO**

(Circle *yes* if ***any*** of the following apply: Blood transfusion prior to 1992, exposure to blood through employment related needle sticks, IV drug use, tattoos or body piercing, excessive alcohol use, or exposure to body fluids through unprotected sex)

WOMEN:

Last Pap: _____

Last mammogram: _____

MEN:

Last prostate exam: _____