Registration Card & Patient Information

Name:_____ Date of Birth:_____
Address:_____ SSN:_____
City:_____ Home #:_____
State:_____Zip:_____ Cell #:_____

Responsible Party if Different Than Above
Name:_____ Date of Birth:_____
Address:_____ SSN:_____
City:_____ Home #:_____
State:_____Zip:_____ Cell #:_____

I hereby grant permission to the Family Care Center of Quitman, Drs Olson and Swinford, to employ such medical, lab and x-ray procedures as considered necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency, or its intermediary, any information needed for related insurance claims. I further permit a copy of this authorization to be used in place of the original. The scanned copy of this permit will be considered the permanent copy of this document.

I understand that when I schedule an appointment time, that I am scheduling time to discuss my health and my related issues. Under no circumstances will I discuss the health care of my family member or friend at my appointment time with or without them present. _____Initials

I authorize payment of medical benefits to the physicians for services rendered. _____Initials

When arriving late for a scheduled appointment, you may be asked to reschedule to a later time that day and possible several days in the future. If you are frequently late for appointments or do not call with 24 hours notice, you may be asked to use available work in slots only in the future. _____Initials

After hours services are not always available. The Family Care Center NEVER provides after hours emergency services. If you have an emergency that cannot wait until office hours, or until a physician returns a phone call or a page, you will use emergency services such as 911 or the Hospital Emergency Room. If I feel that I need immediate care in such instances, I will use the emergency room or 911 Services. _____Initials

Most prescription refills are called in the day they are requested. Please, allow at least 3 office days before running out of medications to get prescriptions refilled allowing physicians time to review and renew medications, schedule a necessary appointment if it cannot be refilled, and allow the pharmacy to order the medication if needed. In general, prescriptions that have not been written for in this clinic require an appointment to review those medications. If you need multiple medications refilled you will need an appointment. _____Initials
I give authorization to release normal lab results on to my answering machine or to a relative answering the telephone. The nature and type of labs will not be released. _____Initials

I understand that I am financially responsible for charges regardless of insurance coverage and/or insurance payment. Payment is due at the time of service and any outstanding balances need to be paid prior to my next office visit. I understand that I am completely responsible for payment regardless of expected third party payment (such as a insurance company from a motor vehicle accident, a court settlement, injury at work, etc.) I will not withhold payment from my medical services until I receive payment from such third parties. _____Initials
I have received a copy of the Notice of Privacy Practices. _____Initials

_____ _____ _____
Printed Name Signature Date

Disclosure to Family/Friends

_____**I do not** authorize Family Care Center of Quitman (provider) to disclose any information concerning my care, treatment or billing by Provider to individuals without my express written consent or legal authorization.

_____**I authorize** Family Care Center of Quitman (provider) to disclose information related to my care and treatment to the following named individuals:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

_____**I authorize** Family Care Center of Quitman (provider) to discuss information related to my bill with the following named individuals:

Name: _____ DOB: _____

Do we have permission to:

1. Leave a message on your answering machine? Y / N
2. Leave a message on your cell phone voice mail? Y / N

I hereby authorize the release of any and all medical records maintained in the office of Family Care Center of Quitman pursuant to my care and treatment to a medical facility practice for possible further treatment.

Signature: _____ Date: _____

*****We are excited to announce the launch of our patient portal. The patient portal gives you access to your medications list, appointment scheduling, and direct messaging with the doctor nurse, and office staff to address any questions and concerns you have with a simple click of a button. If you are interested, please just write your email address down below and you will receive an email and be given a token number to log in. *****

Email Address: _____

_____ **I do not want to participate in the patient portal.**

Please name all of the minors, that are our patients, which you are the guarantor for below:

_____

Health History

Name:_____ Age:_____ Date:_____

Are you employed? YES/NO

If yes, where are you employed?_____

Marital status: Single Married Divorced Widowed

What is the reason for today's visit?_____
_____
_____
_____

Are you currently under the care of a physician for any reason? YES / NO
If yes: Who is you physician?_____
What is your condition?_____

The other Doctors that I see are:

Cardiologist_____ Oncologist_____
Pulmonologist_____ Gastroenterologist_____
Dermatologist_____ Endocrinologist_____
Other_____

During today's visit I would like the following issues addressed:_____
_____
_____
_____

Have you seen another physician for this? YES / NO Who?_____

What tests have you had done for this problem?_____
_____

Would you like a physical? YES / NO

(A physical includes exam, blood work, referrals as needed, and any preventative health care recommendations.)

What pharmacy does the patient use?_____

Where is that located?_____

Current Medications

Medication	Dosage	How often is it taken?	How long have you been taking this medication	Prescribing physician

Are you currently taking Aspirin? YES / NO
If yes, how long have you been taking aspirin?_____

Are you allergic to any medications? Penicillin Sulfa Codeine
Other:_____

Which herbs and/or Vitamins do you take?_____
_____
_____

RECOMMENDED PREVENTATIVE HEALTH

CHECK -UP	MOST RECENT DATE	RESULT
Cholesterol		
Blood Pressure		
Mammogram		
Age 50 + Colonoscopy		

PATIENTS MEDICAL PROBLEMS

_____Glaucoma	_____Hypertension	_____Substance use
_____Psychiatric care	_____Suicide attempt	_____Diabetes
_____Anemia	_____Arthritis	_____Pacemaker
_____Gout	_____High Cholesterol	_____Emphysema/COPD
_____STD	_____Thyroid problems	_____Pneumonia
_____Angina	_____Tuberculosis	_____Epilepsy
_____Hepatitis	_____Chronic Kidney Disease	_____Cancer
_____Blood transfusion	_____Ulcers	_____Eating Disorder
_____Hernia	_____Bronchitis	_____Cataracts
_____AIDS	_____Liver Disease	_____Vitamin Deficiency

FAMILY HISTORY

DISEASE	RELATIONSHIP TO YOU					
Asthma	Mother	Father	Siblings	Aunt	Uncle	Other
Cancer	Mother	Father	Siblings	Aunt	Uncle	Other
What type?						
Chemical Dependency	Mother	Father	Siblings	Aunt	Uncle	Other
Diabetes	Mother	Father	Siblings	Aunt	Uncle	Other
Heart attack before age 55	Mother	Father	Siblings	Aunt	Uncle	Other
Stroke	Mother	Father	Siblings	Aunt	Uncle	Other
Heart disease/Hypertension	Mother	Father	Siblings	Aunt	Uncle	Other
Kidney Disease	Mother	Father	Siblings	Aunt	Uncle	Other

HEALTH HABITS

HABIT	CURRENTLY USING	USED IN THE PAST	HOW OFTEN	HOW MUCH
Caffeine	Y/N	Y/N		
Second-hand smoke	Y/N	Y/N		
Alcohol	Y/N	Y/N		
Tobacco	Y/N	Y/N		
Exercise	Y/N	Y/N		
Street Drugs	Y/N	Y/N		

SURGERIES/HOSPITALIZATIONS

Year	What type of Surgery?

TESTING HISTORY

TEST		DATE (Estimate) / RESULT
MRI	Y/N	
Cat Scan	Y/N	
Sleep Study	Y/N	
Cardiac Stress Test	Y/N	
Echocardiogram	Y/N	
PSA	Y/N	
EKG	Y/N	
Chest X-Ray	Y/N	

I have had the following immunizations:

IMMUNIZATIONS	DATE
Tetanus	
Pneumonia	
Flu	

CURRENT CONDITION CHECKLIST

CONSTITUTIONAL

___Chills
___Fainting
___Fever
___Insomnia
___Weight Loss
___Weight Gain
___Fatigue
___Decreased Appetite
___Sweats
___Nervousness

EAR, NOSE, & THROAT

___Difficulty swallowing
___Earache or Drainage
___Hearing Loss
___Ringing in the ears
___Sinus problems
___Sore throat
___Bleeding gums
___Nose bleed
___Ear discharge
___Facial pain/sinus pressure

EYES

___Double vision
___Watering
___Blurring vision
___Painful
___Redness

SKIN

___Bruise easily
___Change in moles
___Hives
___Itching
___Yellow skin (jaundice)
___Acne

HEART

___ Chest Pain
___Rapid/Irregular beat
___Swelling in the feet

NEUROLOGICAL

___Dizzy
___Headache
___Numbness/shaking
___Tremors
___Memory Loss

URINARY

___Blood in urine
___Frequency
___Loss of control
___Painful urination
___Urgency
___Straining
___Nighttime urination

ENDOCRINE

___Goiter
___Growth changes
___Heat Intolerance
___Cold Intolerance

RESPIRATION

___Asthma
___Coughing up blood
___Short of Breathe
___Night-time cough
___Wheezing
___Persistent cough

Muscle/Joint/Bone

Pain or Weakness in:

___Arms
___Back
___Feet
___Hands
___Hips
___Fracture, describe:
_____
___Leg
___Neck
___Shoulder

Genital/Urinary

Women

___Pregnant
___Bleeding between Periods
___Breast Lumps
___Hot Flashes
___Extreme Menstrual Pain
___Nipple Discharge
___Painful Intercourse
___Vaginal Discharge

Men

___Blood in Urine
___Frequent Urination
___Lack Of Bladder Control
___Painful Urination
___Urgency
___Straining
___Night-Time Urination
___Difficulty with intercourse
___Erectile Difficulty

Gastrointestinal

___Bloating
___Bowel Changes
___Diarrhea
___Constipation
___Excessive Hunger
___Excessive Thirst
___Gas
___Heartburn/Indigestion
___Nausea or Vomiting
___Rectal Bleeding
___Vomiting Blood
___Stomach Pain