Registration Card & Patient Information

Name:_____ Date of Birth:_____
Address:_____ SSN:_____
City_____ Home #:_____
State:_____ Zip:_____ Cell #:_____

Responsible Party
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. _____Initials

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, I may be asked to reschedule to a later date, possibly several days in the future. If I am frequently late for appointments, or do not call with 24 hour notice, I may be asked to use available work in slots only in the future. If I miss more than 2 appointments in a 12-month period I may be asked to pay a no-show fee prior to scheduling any additional appointments. _____Initials

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

I will request all prescription refills at least 3 office days before I run out of medications. This allows my physician time to review and renew medications, schedule a necessary appointment if my medications cannot be refilled, and allows the pharmacy time to order the medication if needed. In general, prescriptions that have not been written for me in this clinic will require an appointment to review those medications. _____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 must be paid prior to my next office visit. I understand that I am completely responsible for payment regardless of expected third party payment (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

I authorize Family Care Center of Quitman (provider) to discuss information related to _____'s medical care and treatment to the following named individuals.

Legal Name	DOB	Relationship to Patient

Please list the following individuals that are allowed to bring _____to our clinic for sick visits and Well Child appointments.

Legal Name	DOB	Relationship to Patient

**Person or persons that are authorized to bring the patient are responsible for the payment at time of service.

_____ _____ _____

Print Name Signature Date

HEALTH HISTORY

Name _____ Age _____ Date _____

Is the patient currently under the care of a physician for any reason? Yes_____No_____

If yes, what is your condition and who is your physician?_____

What is the reason for today's visit?_____

_____

_____

_____

_____I have a cold

When did it start?_____

When was your last cold?_____

Is anyone else around you sick?_____Yes___No.

What medications are they taking?_____

_____My_____hurts.

When did it start?_____

What makes it better?_____

What makes it worse?_____

What do you think caused it?_____

What type of pain is it?_____Sharp___Dull___Throbbing___Other

How often is it occurring?___All Day_____Several Times a day

Only when I do certain things_____Other_____

Have you seen another physician before this?_____Yes___No

What tests have you done?_____

_____

If there is additional time during this visit, are there other concerns you would like to address today?_____

_____

_____

Current Medications

Medications	Dosage	How often is it taken?	How long have you been taking this medication?	Prescribing Physician

Is the patient allergic to any medications?

_____Penicillin_____Sulfa____Codeine____Other_____

What herbs, vitamins do you take?_____

_____

Do you take aspirin?____Yes____No

Childhood Illness & Problems

_____Anemia	_____Strep Throat	_____Vision Problems
_____Hepatitis	_____Developmental Delays	_____Hearing Problems
_____Pneumonia	_____Lead Exposure	_____Seizures
_____Bladder Infections	_____Asthma	_____Eczema
_____Ear Infections	How Many?_____	

Surgeries/Hospitalizations

Year	What type of surgery?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

Family History

Use ***X*** to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or Manic depressive Disorder									
Colon or rectal cancer									
Breast cancer									
Other Cancer									
Other:									

CURRENT CONDITION CHECKLIST

ENDOCRINE

_____Goiter
_____Growth changes
_____Cold Intolerance
_____Heat Intolerance

CONSITUTIONAL.

_____Chills
_____Fainting
_____Fever
_____Decreased Appetite

EAR, NOSE, & THROAT

_____Difficulty Swallowing
_____Earache or Drainage
_____Ear Discharge
_____Ringing on the ears
_____Sore Throat
_____Nose Bleed
_____Hearing Loss

EYES

_____Redness
_____Watering
_____Blurring Vision
_____Painful
_____Double Vision

ALLERGIES

_____Hay Fever
_____Seasonal

NEUROLOGICAL

_____Dizzy
_____Numbness/Shacking
_____Headache
_____Loss of Consciousness

SKIN

_____Hives
_____Yellow skin (jaundice)
_____Itching
_____Rash

HEART

_____Chest Pain
_____Swelling in the feet
_____Rapid/Irregular Beat

URINARY

_____Blood In Urine
_____Frequency Urination
_____Painful Urination
_____Urgency
_____Toilet Training Problems
_____History of Bladder Infection

RESPIRATION

_____Asthma
_____Persistent Cough
_____Short of Breath
_____Night Time Cough
_____Wheezing
_____Coughing up Blood

MUSCLE/JOINT/BONE

Pain or Weakness in:

_____Arms
_____Back
_____Feet
_____Shoulder
_____Hands
_____Fracture, Describe:
_____
_____Leg
_____Hips

GASTROINTESTINAL

_____Bloating
_____Bowel Changes
_____Diarrhea
_____Constipation
_____Excessive Hunger
_____Excessive Thirst
_____Gas
_____Stomach Pain
_____Nausea or Vomiting
_____Rectal Bleeding
_____Vomiting Blood
_____Heartburn/Indigestion

OTHER

_____
_____
_____
_____
_____

FOOD ALLERGIES

_____
_____
_____
_____

HEALTH HISTORY

Who lives at home with the patient?_____Mother_____Father_____Both
_____Grandparents_____Other_____

Who is the patients primary caretaker?____Mother_____Father_____Both
_____Grandparents_____Other_____

Are pets at home with the patient?__Yes___No

Is the patient regularly exposed to second-hand smoke?___Yes___No

Does the patient attend daycare?___Yes___No

Is the patient current with his/her shots?___Yes___No

Has the patient ever had a blood transfusion?_____Yes___No
If yes please give date(s)_____

What pharmacy do you use?_____

Maternal Complications

Did the mother experience any of the following during pregnancy with this child?

- o Dental Disease
- o Vaginal bleeding
- o High Blood Pressure
- o Premature Labor
- o Kidney Infection
- o Anemia
- o Gestational Diabetes
- o Sexually Transmitted diseases
- o Injured or hospitalized
- o RH Negative
- o Tb exposure
- o Flu illness/ high temp
- o Lead exposure

Decribe the Patients Diet:

Breast Fed? _____ Yes _____No

If no then, what type of milk or formula does the patient take?

Milk_____

Formula_____

I confirm that the above information is correct to the best of my knowledge. I will not hold my doctor or any other members of his/ her staff responsible for any errors or omissions I may have make in the completion of this form.

Signature of Patient's Parent/ Guardian Date