Friendly Family Medical Care, Inc.
REGISTRATION FORM

(Please Print)

Today's Date:	Where did you previously receive your care?

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Dr.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer's phone number: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card/cards to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance

Subscriber's Name:

Subscriber's Phone:	Subscriber's S.S. number:	Subscribers DOB:	Group number:	Policy number:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name and Birth date:	Group number:	Policy number:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

ORIGINAL DATE:
DATES REVISED:

Friendly Family Medical Care, Inc.

640 Bankview Drive
Suite 2
Frankfort, IL 60423

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous doctor:	**DATE OF LAST PHYSICAL EXAM:**

Referred by/How did you hear about us?:

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
	Do you currently use recreational or street drugs?				☐ Yes	☐ No

	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			*Children*	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDM OTHER** *Maternal*		
	☐ M ☐ F		**GRANDFA THER** *Maternal*		
	☐ M ☐ F		**GRANDM OTHER** *Paternal*		
	☐ M ☐ F		**GRANDFA THER** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Effective Date: January 3, 2009

Friendly Family Medical Care, Inc.
640 Bankview Drive, Suite 2
Frankfort, IL 60423

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not fear about providing information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will - -

- Adhere to the standards set forth in the Notice of Privacy Practices.

- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

- Use and disclose PHI to remind patients of their appointments only within their consent.

- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.

- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patients' individual dignity at all times. Our practice and its physicians and staff will respect patients' privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:

    1. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

    2. Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will- -

    1. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.

    2. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

Effective date: January 3, 2009

- **All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.**

- **All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.**

- **Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.**

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name _____ Birthdate_____

Patient's Signature _____

Patient's Representative _____Relationship_____

Representative's Signature _____

Date _____

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION

1. **I, (Print) _____, hereby give my consent to Friendly Family Medical Care, Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record. (Print Patient's Name):**

   _____

   If you are not the patient, please specify your relationship to the patient.

2. **I understand that this consent is valid until it is revoked by me through a written notice to the physician at this office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY INFORMATION CHANGES.**

A. What phone numbers may the physician and office staff use to call you?

(H)_____(W)_____(C)_____

B. Who may we leave messages for appointments and return calls with?

Name(s) _____
Phone Number(s) _____
Answering Machine: Yes_____ No _____

C. Who may we leave messages regarding test results and medication with?

Name(s)_____
Phone Number(s)_____
Answering Machine: Yes _____ No _____
May we fax pertinent information to other providers or yourself? Yes _____ No _____
Personal Fax Number _____
Email address _____

Signature:_____Date:_____

Friendly Family Medical Care Inc.

640 Bankview Drive
Suite 2
Frankfort, IL 60423
815-464-0081

No Call – No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No-Show, No-Call.") A fee of $50.00 will be charged to you for a missed appointment. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments. Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment will be cancelled.

Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. It also makes it possible to reschedule your appointment more efficiently.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify.

Thank you,
Friendly Family Medical Care Staff

Patient Printed Name: _____

Signature/Date: _____