

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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Dr.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name and Birth date:			Group number:	Policy number:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative:		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>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.</p>				
<hr/> <i>Patient/Guardian signature</i>			<hr/> <i>Date</i>	

Friendly Family Medical Care, Inc.

640 Bankview Drive

Suite 2

Frankfort, IL 60423

IBCCP HEALTH HISTORY QUESTIONNAIRE

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

NAME <i>(Last, First, M.I.)</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:			
MARITAL STATUS:	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED						

SURGERIES		
Year	Reason	Hospital

PRESCRIBED 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

TOBACCO	
Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what kind?	
How many years using tobacco?	
Cigarette - packs per day?	

Chewing - amount per day?
Pipe - amount per day?
Cigars - amount per day?
If you quit, what year?

ALCOHOL	
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Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what kind?	
How many drinks per week?	
Are you concerned about the amount you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you considered stopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced blackouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you prone to "binge" drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drive after drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HISTORY	
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Does your family have a history of breast cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your family have a history of cervical cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your family have a history of ovarian cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your family have a history of colon cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

REPRODUCTIVE HISTORY	
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Age at onset of menstruation:	
Date of last menstruation:	
Period occurs every _____ days	
Any heavy periods, irregularity, spotting, pain, or discharge?	
Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contraceptive or barrier method used: _____	
Number of pregnancies _____ Number of live births _____	
Have you had a D&C, hysterectomy, or Caesarean?	
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last pap and rectal exam:	
When was your last mammogram?	

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.**
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- 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 share information with you via fax?: Yes _____ No _____

Email address _____

Signature: _____ Date: _____



Friendly Family Medical Care Inc.

640 Bankview Drive
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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: _____