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*

PEDIATRIC HEALTH HISTORY FORM

NAME: _____

DATE OF BIRTH: _____

AGE: _____

Your relationship to child: _____ **Allergies**: _____

Medicines/Vitamins: _____ **Herbs/Home Remedies**: _____

Present health concerns:

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____

Please indicate any medical problems during pregnancy

☐ None Specify:

_____

Delivery by: ☐ Vaginal birth ☐ Caesarean

If Caesarean, why?

_____

Birth weight: _____ Birth Length: _____

Discharge weight:_____

Please indicate any medical problems during the baby's newborn period: ☐ None (if premature, how early?)

_____

Other problems:

_____

FAMILY HISTORY

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Diabetes _____

Alcoholism _____

High Cholesterol _____

Cancer, specify type _____

High Blood Pressure _____

Heart Disease _____

Stroke _____

Depression/suicide_____

Bleeding or clotting disorder _____

Genetic disorders _____

Asthma/COPD _____

Other: _____

NUTRITION & FEEDING

Has your child had any usual feeding/dietary problems?

☐ No ☐ Yes If yes, specify:_____

Milk intake now: _____

Average ounces per day: (Note: 8 ounces = 1 cup)_____

SLEEP

Hours per night: _____

Naps (number & length): _____

Any sleep problems? _____

_____

EXPOSURE & HABITS

Any concerns about lead exposure?

(old home/plumbing/peeling paint) ☐ No ☐ Yes

Do any household members smoke, whether inside or outside of home? ☐ No ☐ Yes

Are there any pets in the home? ☐ No ☐ Yes

TV- hours per day:_____

Computers- hours per day:_____

Video games- hours per day:_____

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents: ☐ Married ☐ Unmarried

☐ Separated, when? _____ ☐ Divorced, when? _____

Mother's Occupation _____

Mother's Employer _____

Father's Occupation _____

Father's Employer _____

Child care situation: ☐ Parents ☐ Others (specify who and how often) _____

Is violence at home a concern? ☐ No ☐ Yes

Are there guns in the home? ☐ No ☐ Yes

Concerns about your child: ☐ Alcohol ☐ Tobacco ☐ Sexual Activity ☐ Aggressive behavior

DEVELOPMENT

At what age did your child: Sit alone_____
Walk alone_____ Say words_____

Toilet train (daytime)_____

Girls only: Age at first menstrual period _____

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates?

_____
_____
_____

Hospitalization/operations (with dates):

_____

Broken bones or severe sprains:

_____

INFECTIOUS DISEASES

Has your child had any of the following diseases:

☐Chickenpox ☐Measles ☐Mumps
☐ Rubella ☐Meningitis ☐ Tuberculosis
☐Other: _____

DENTAL HISTORY

Has your child been seen by a dentist? ☐No ☐Yes
If so, how often? _____
Date of last visit _____

SCHOOL HISTORY

Did/does your child attend school or preschool?
☐No ☐Yes

Current grade _____

Name of School _____

Any concerns about school performance?

_____

Any concerns about relationship with:
Teachers ☐No ☐Yes
Peers ☐No ☐Yes

If more than 4 years old, does your child have a best friend?
☐No ☐Yes

Sports/exercise: Type _____

How often? _____

How long (minutes)? _____

REVIEW OF SYMPTOMS

Please check any current problems your child has on the list below:

General
___ Fever /chills excessive sweating
___ Unexplained weight loss/gain

Eyes
___ Squinting/"crossed" eyes

Ears/Nose/Throat
___ Unusually loud voice/ hard of hearing
___ Mouth breathing/snoring
___ Bad breath
___ Frequent runny nose
___ Problems with teeth/gums

Cardiovascular
___ Tires easily with exertion
___ Shortness of breath
___ Fainting

Respiratory
___ Cough/wheeze
___ Chest pain

Gastrointestinal
___ Nausea/vomiting/diarrhea
___ Constipation
___ Blood in bowel movement

Genitourinary
___ Bedwetting
___ Pain with urination
___ Discharge: penis or vagina

Musculoskeletal
___ Muscle/joint pain

Skin
___ Rashes
___ Unusual moles

Allergy
___ Hay fever/itchy eyes

Neurological
___ Headaches
___ Weakness
___ Clumsiness

Psychiatric/Emotional
___ Speech problems
___ Anxiety/stress
___ Sleep issues
___ Depression
___ Nail biting/thumb sucking
___ Bad temper/breath holding/ jealousy

Blood/Lymph
___ Unexplained lumps
___ Easy bruising/bleeding

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.

Effective date: January 3, 2009

- **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.**

- **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.**

Friendly Family Medical Care, Inc.

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: _____