REGISTRATION for office of Amelia Pare MD 123 Hidden Valley Road

Date of Visit_____Name:_____

Date of Birth:_____Age:_____Male____Female____ Race:_____

Last 4 Digits Social Security#_____ Marital Status: Single Married Divorced Widow

Address:_____City:_____State:___ Zip:_____

Home phone:_____Cell:_____Work:_____

Email address:_____

Occupation: _____

Emergency Contact:_____Relationship:_____ Phone#_____

Pharmacy name/location:_____Pharmacy Phone:_____

Family physician:_____Physician Phone:_____

May we leave a message on your voicemail/answering machine at home ? Yes__ No__

May we leave medical information with a family member? Yes__ No__

May we contact you at work? Yes ___No___

Source of referral? Family physician Friend Other, explain_____

INSURANCE Information

Primary Insurance:_____

Member ID:_____Group:_____

Phone number:_____Address:_____

Policy holder name: _____Date of Birth:_____

Relation to Insured: Spouse Parent Self Copay:_____

Secondary

Insurance:_____

Member ID:_____Group :_____

Phone number:_____Address:_____

Policy holder name: _____Date of Birth:_____

Relation to Insured: Spouse Parent Self Copay:_____

Financial Authorization: I hereby authorize Dr Amelia Pare' to furnish information to insurance carriers and or health care providers concerning this illness/accident. I hereby irrevocable assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of responsible party:_____Date:_____

Photo Authorization I hereby authorize Amelia Pare to take my photograph and use it in my chart for insurance authorization.

Signature of responsible party:_____Date:_____

Authorization for Disclosure of Protected Health Information: *I authorize the entity listed below to receive my protected health information.* The protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice of Dr Pare'. This authorization will expire at the end of calendar year of your last signature below. I have the right to terminate at any time. The privacy policy is detailed and available in the reception area and upon request. I acknowledge that I am aware of the privacy practices of Dr Pare' and give my consent to Dr Pare to perform medial services necessary for the benefit of my health. Dr. Pare is the privacy officer. For telemedicine patients, please let us know if you would like copies of these policies.

*Family Doctor:*_____Date:_____

*Spouse/Partner:*_____Date:_____

Other_____relationship_____Date:_____

Signature of responsible party:_____Date:_____

Medicare Certification: I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize the use of my protected health information to be released to the Centers for Medicare and Medicaid. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician providing the services.

Signature of responsible party: _____Date:_____

Dr Pare complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, or sexual orientation. Welcome to our practice.

Name_____ **Date of Birth**_____ Height____ Weight____

Reason for visit and duration:_____

Drug Allergies and reaction:_____ Latex allergy Yes__ No__

Mediciations:_____

Vitamin & herbal supplements:_____

Medical conditions:_____

Hospitalizations:_____

Operations:_____

Review of Systems Have you had any of the following: If yes, *CIRCLE* please explain

Yes No Chest pain or pressure_____

Yes No Shortness of breath, asthma or wheezing_____

Yes No Frequent and severe headaches_____

Yes No Nausea and or Vomiting_____

Yes No Dizziness and /or fainting_____

Yes No Seizures_____

Yes No Weight loss (amount and time frame)_____

Yes No Change in vision_____

Yes No Swelling in legs and feet_____

Yes No Blood Clots and/or circulation problems_____

Yes No Heart murmur or Rheumatic fever_____

Yes No Sinus problems, seasonal allergies_____

Yes No Diabetes_____

Yes No High blood pressure, high cholesterol_____

Yes No Stroke_____

Yes No Hepatitis_____

Yes No Urinary burning/frequency_____

Yes No Cancer_____

Yes No Sexually transmitted disease _____

Yes No Wound healing problems,

Yes No Hair loss, weight gain or loss, easy bruising, tiredness _____

Yes No Weight gain or loss (state how much and time frame)_____

Yes No MRSA_____

Yes No Burning, itchy, or dry eye and/or excessive tearing_____

Yes No Snoring and/or sleep apnea_____

Yes No Anxiety and/or depression and/or Trouble sleeping_____

Social History

Yes No Do You smoke? How much and how long_____ Would you like to quit?___

Yes No Do you consume alcohol? Amount_____

Family History If yes, please *CIRCLE* and explain what family member:

Yes No Bleeding problem _____

Yes No Diabetes _____

Yes No Heart disease/Stroke _____

Yes No Cancer, type_____

Yes No Problem with anesthesia_____

This form is completed by the patient and reviewed by the physician on _____