Fitzgibbon Family Health
Fayette, MO

Registration Form

PATIENT NAME: ______________________ Birth Date: __________
Address (Street, Apt #): ______________________ Social Security #: __________
City: ______________ State: ______ Zip: ________ County: __________
Home Phone: (   ) ______________ Sex: _____ Race: __________ Religion: __________

MAIDEN NAME: ______________ (Single patients or male patients give mother's maiden name)
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

PATIENT EMPLOYER

Name: ______________________ Employer Phone: (   ) __________
Address: ______________________ Occupation: __________
Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

PERSON TO NOTIFY

Name: ______________________ Phone: (   ) __________
Address: ______________________ Relationship: __________

NEXT OF KIN *(If same as PERSON TO NOTIFY, leave blank)*

Name: ______________________ Phone: (   ) __________
Address: ______________________ Relationship: __________

GUARANTOR *(Who is responsible for bill - self or who is bringing patient in today if minor - NOT INSURANCE)*

Name: ______________________ Phone: (   ) __________
Address: ______________________ Social Security #: __________

GUARANTOR EMPLOYER

Name: ______________________ Employer Phone: (   ) __________
Address: ______________________ Occupation: __________
Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

IF PATIENT IS A MINOR we need both parents' employment information. This section is for the parent that is NOT listed in the Guarantor information above.

Name: ______________ SS#: __________ Date of Birth: __________
Address: ______________________ Relationship to Patient: __________
Employer Name/Address: ______________________ Phone: __________
Employment Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed

	INSURANCE	POLICY NO.	COVERAGE NO.	SUBSCRIBER	REL	OFFICE CO-PAY
1.						
2.						

Primary Care Physician: ______________ Reason for Visit: ______________

READ AND SIGN

I hereby authorize payment directly to my physician's office, of any insurance coverage for treatment rendered, and authorize them to release any information necessary to process these insurance claims. I understand that I am fully responsible for all services and charges, including any balance due after payment of insurance, and that insurance coverage does not necessarily pay all charges. I also understand that doctor and office fees are due and payable when services are rendered.

I, the undersigned, authorize treatment by the physician of this office.

PATIENT SIGNATURE: ______________________ DATE: __________
(If minor, parent or guardian signature)

Form ID#: FFH01

Fitzgibbon Family Health
Fayette, MO

Patient Health History

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY!

Name: ______________________________ Birth Date: ______________

Age: ________ Sex: ________ Marital Status: ______________ Occupation: ______________

PAST HEALTH HISTORY

Please list all previous hospitalizations, surgeries, injuries, and blood transfusions. Include dates, hospitals, and physicians.

____

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____

____

____

CURRENT HEALTH STATUS

ALLERGIES: Include any medications, foods, or other things to which you are allergic.

____

____

CURRENT MEDICATIONS: Please list all medications which you are currently taking (be sure to include over-the-counter, contraceptives, and medications taken only occasionally).

Name of Medication	Strength	How Often	Date Began	Date Last Taken

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

High Blood Pressure	Y	N	Bleeding Disorder	Y	N
Heart Disease	Y	N	Thyroid Disorder	Y	N
Stroke	Y	N	Liver Disease	Y	N
Diabetes	Y	N	Epilepsy/Seizures	Y	N
Cancer	Y	N	Asthma	Y	N
Lung Disease	Y	N	Kidney Disease	Y	N
Ulcers	Y	N	Alcohol/Drug Addiction	Y	N
Arthritis	Y	N	Anxiety	Y	N
Headaches	Y	N	Depression	Y	N
Anemia (low iron)	Y	N	H.I.V.	Y	N

Please list other illnesses which you think would be important to your care.

____

____

____

LIFE HABITS:

1 Do you use, or have you ever used, tobacco in any form? Y N
If yes: Age started________ Age quit_______ Type and amount______________________________

2 How much coffee, tea, and/or soda do you drink in a day?________________________

3 How much alcohol do you drink?
Daily_____ Weekly_____ Less than 3 per month_____ Never_____

4 How many hours of sleep do you get within a 24-hour period?________
Do you generally feel rested? Y N

5 What types of exercise do you practice?
Running_____ Aerobics_____ Walking_____ None_____ Other_____

6 What activities do you do for fun?____

7 Former schooling:____

8 Occupation:____

FAMILY HEALTH HISTORY:

To your knowledge, do any of your immediate family members have the following? If yes, who?

High Blood Pressure	________________________	Bleeding Disorder	________________________
Heart Disease	________________________	Thyroid Disorder	________________________
Stroke	________________________	Liver Disease	________________________
Diabetes	________________________	Epilepsy/Seizures	________________________
Cancer	________________________	Asthma	________________________
Lung Disease	________________________	Kidney Disease	________________________
Ulcers	________________________	Alcohol/Drug Addiction	________________________
Arthritis	________________________	Anxiety	________________________
Headaches	________________________	Depression	________________________
Anemia (low iron)	________________________	H.I.V.	________________________

____ ________________________
PATIENT'S SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received or I have been provided the opportunity to receive a copy of the Notice of Privacy Practices that explains when, where, and why my confidential information may be used or shared. I acknowledge that Fitzgibbon Hospital and its affiliates, the physicians, the nurses, and other Fitzgibbon Hospital staff my use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Fitzgibbon Hospital's operations and responsibilities.

Patient Name ______________________________ Relationship to Patient ______________

Signature ____
Patient (or Designated Representative)

Date ________________________________ Witness ______________________________

In order to help control the cost of billing, we request payment be made for all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature ____

Date ____