❑ FHC at Biltmore ❑ FHC at Cane Creek ❑ FHC at Newbridge ❑ FHC at Enka/Candler

❑ Center for Psychiatry ❑ Deerfield ❑ Givens

MAHEC

FAMILY HEALTH CENTERS PATIENT REGISTRATION FORM

Please complete the following information using BLACK ink. ****This information is confidential****

Name _____ SS #_____

Address _____ City_____State_____ Zip_____

Home county _____E-mail address _____

Home phone _____ Work/cell phone _____

By providing a phone number, mobile phone number or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Birth Date _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ In a relationship ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

In case of emergency, contact:

Name_____ Relationship _____ Phone #_____

IF PATIENT IS CHILD (18 & UNDER): Responsible Party Name:_____

Relationship to patient _____ Phone #_____

Please list: Special hearing needs: _____ Special vision needs: _____

What is your race / ethnicity? (check all that apply):

❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Other Pacific Islander

❑ Black or African American ❑ Hispanic or Latino ❑ White ❑ Other (please describe):_____

Preferred Language: ❑ English ❑ Spanish ❑ American Sign Language ❑ Russian ❑ Other_____

INSURANCE INFORMATION

Insurance company _____

Policy holder's name _____ Policy holder's date of birth _____

Policy holder's relationship to patient: _____

Policy holder's address: _____

_____

Policy holder is ❑ male ❑ female Policy ID# _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid and/or Medicare benefits directly to MAHEC Family Health Center and I authorize them to file insurance on my behalf. I also authorize them to release medical/and or account information to my insurance, Medicaid and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand MAHEC Family Health Center:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice

.

I have read and understand the above: _____ Date_____

Patient or Guardian Signature

Note: Failure to sign does not relieve you of the above expectations

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient, Parent or Guardian Signature _____ Date_____

VERBAL COMMUNICATION CONSENT

MAHEC is authorized to discuss medical and financial information concerning the care and services provided to me with the following individuals:

_____ _____

_____ _____

Today's Date: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) for treatment, payment, and healthcare operations when necessary.

Patient, parent or guardian signature _____ Date_____

FOR OFFICE USE ONLY: Primary Care Provider _____

Copy of insurance card obtained? ❑ yes ❑ no

MAHEC

Family Health Center Sports Medicine
Intake Form

PATIENT NAME _____ **DATE OF VISIT** _____

FORM COMPLETED BY _____ **DATE OF BIRTH** _____

Have you received medical care from another family physician, pediatrician or internist in the last 5 years?
Please give name and city.

_____

ALLERGIES OR BAD REACTIONS TO MEDICINES
Please list the medicine which bothers you and the bad reaction it causes, or check that you have no allergies

❑ No allergies

Name of Medicine	**Reaction caused**

MEDICATIONS
Please list ALL medications you are currently take (including birth control pills, vitamins and herbs), even if you do not take them every day, and even if they are over the counter.

Name of medication	**Dose size (usually mg)/#tabs**	**How often taken**

More can be listed below under additional medications

PHARMACY
Local: _____

Mail Order: _____

MENTAL HEALTH
During the past month have you often been bothered by:
Little interest or pleasure in doing things? ❑ Yes ❑ No
Feeling down, depressed, or hopeless? ❑ Yes ❑ No
In the last 4 weeks, have you had an anxiety attack - suddenly feeling fear or panic? ❑ Yes ❑ No

FOR WOMEN ONLY
Reproductive history
How many pregnancies _____
How many live births _____
How many miscarriages _____
How many C-sections _____
Ever had abnormal pap smears ❑ Yes ❑ No
When was your last pap _____
Was it normal ❑ Yes ❑ No
When was your last mammogram _____
Was it normal ❑ Yes ❑ No
Menopause (change of life) since _____

ADDITIONAL MEDICATIONS