Mooresville Family Practice **Patient Registration Form**

PATIENT INFORMATION

Name: Birth Date: S.S. No.:

Street: City: State: Zip:

Home Phone No: Cell No.:

Email: _____ Contact Preference:_____ How did you hear about us:_____

Sex: Marital Status: Language: Race: Ethnicity:

Employer: _____ Work Phone No: _____ Ext: _____

Spouse (or Parent if minor): _____ Spouse Phone No.: _____ Ext: _____

Pharmacy: _____ Preferred Lab: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: S.S. No.:

Street: City: State: Zip:

Home Phone No:_____ Ext: _____ Work: _____ Ext:_____

Employer: _____ Work Related Injury? _____

Date of Injury: _____ Has an L&I claim been filed?_____ If yes, What is the claim #? _____

Employer – Street: _____ City: _____ State: _____ Zip: _____

Spouse or Parent Name: _____ Spouse or Parent S.S. No.:_____

Spouse or Parent Employer: _____ Work Phone No.:_____

PERSON TO CALL IN CASE OF EMERGENCY

Name:_____ Relationship: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone No.: Work Phone No.: _____ Cell No.: _____

REFERRING PHYSICIAN

Name: _____ Phone No.: _____

Street: _____ City: _____ State: _____ Zip: _____

I, the patient or patient's guardian, accept the responsibility for the payment of all charges at the time the services are rendered. Although I am responsible for the entire amount, including the portion covered by insurance, I also understand that assistance may be provided in filling out necessary forms related to these services when requested by me.

Signature: _____ Date: _____

IF YOU HAVE YOUR INSURANCE CARD PRESENT FOR COPYING, YOU DO NOT NEED TO FILL THIS PAGE OUT

INSURANCE INFORMATION

Please have your card available so that we can make a copy.

Primary

Insurance Company Name:

Street: City: State: Zip:

Policy Holder's Name: Policy Holder's S.S. No.: _____

Policy Holder's Date of Birth: Policy Number:

Group No.: _____

Does Insurance Require Pre-certification? _____ Yes _____ No

If "yes" list phone number for authorization of service _____

_____

Secondary

Insurance Company Name:

Street: City: State: Zip:

Policy Holder's Name: Policy Holder's S.S. No.: _____

Policy Holder's Date of Birth: Policy Number:

Group No.: _____

Does Insurance Require Pre-certification? _____ Yes _____ No

If "yes" list phone number for authorization of service _____

_____

BENEFITS AUTHORIZATION

I request that payment of authorized benefits be made either to me on my behalf or to Mooresville Family Practice for any services furnished to me.

Patient/Guardian Signature _____

Date: _____ Relationship to patient: _____

Name: _____ **DOB:** _____ **Date:** _____ **Age:** _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: _____

Past Medical History

_____
_____
_____
_____

Past Surgical History

_____
_____
_____
_____

Please list allergies of any kind, and include reactions: _____

Present Medications (Please include all prescription and non-prescription medications.)

Name	Dose	Name	Dose
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Obstetrical History # of Pregnancies: _____ # of Children: _____ Age at first live birth: _____
Age of menarche: _____ Age of menopause: _____

Social History/Habits Tobacco: Y/N _____ Type _____ Times per day _____
Exercise: Y/N _____ Times per wk _____ Caffeine: _____
Alcohol: Y/N _____ Times per wk _____ Street Drugs: Y/N _____

FAMILY HISTORY:

		If Living			If Decreased	
Relationship	*Age*	*Health*			*Age at Death*	*Cause*
Father		☐ Good	☐ Fair	☐ Poor		
Mother		☐ Good	☐ Fair	☐ Poor		
Brother/Sisters		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		

Check if any blood relatives (mother, father, brother, sister, aunt, uncle, grandfather, grandmother) have had any of the following:

	YES	NO		YES	NO		YES	NO
Stroke			Epilepsy			Colitis		
Cancer			Emphysema			Rheumatic Heart		
High Blood Pressure			Bleeding Tendency			Congential Heart		
Tuberculosis			Heart Attack			Died Suddenly		
Diabetes			Kidney Disease			Heart Failure		
Leukemia			Arthritis					

MOORESVILLE PPM, LLC

Adult History Questionnaire

106808 (10/09)

_____
Physician Signature

_____
Date

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS
Fever	☐	☐	
Chills	☐	☐	
Fatigue or tiredness	☐	☐	
Cancer	☐	☐	
Unexplained weight gain or loss	☐	☐	
EYES			
Disease/Injury	☐	☐	
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Glaucoma	☐	☐	
EARS/NOSE/MOUTH/THROAT			
Hearing Loss	☐	☐	
Ringing in the Ears	☐	☐	
Earaches/Drainage	☐	☐	
Nosebleeds	☐	☐	
Chronic Sinus Problems	☐	☐	
Mouth Sores	☐	☐	
Sore Throat	☐	☐	
Voice Changes	☐	☐	
Swollen Neck Glands	☐	☐	
CARDIOVASCULAR			
Heart Trouble	☐	☐	
Chest Pain/Angina	☐	☐	
Rheumatic Fever	☐	☐	
Irregular or fast heartbeat	☐	☐	
High Blood Pressure	☐	☐	
Swelling of Feet/Hands	☐	☐	
RESPIRATORY			
Shortness of Breath	☐	☐	
Coughing	☐	☐	
Spitting up Blood	☐	☐	
Asthma/Wheezing	☐	☐	
GASTROINTESTINAL			
Change in Bowel Movements	☐	☐	
Nausea/Vomiting	☐	☐	
Frequent Diarrhea	☐	☐	
Rectal Bleeding/Blood in Stool	☐	☐	
Abdominal Pain/Heartburn	☐	☐	
Peptic or Stomach Ulcers	☐	☐	
Colitis	☐	☐	
Gallbladder disease	☐	☐	
GENITOURINARY			
Frequent Urination	☐	☐	
Burning/Painful Urination	☐	☐	
Blood in Urine	☐	☐	
Incontinence or Dribbling	☐	☐	
Kidney Stones	☐	☐	
Sexual Difficulty	☐	☐	
Male – Testicle Pain	☐	☐	
Female – Irregular Periods	☐	☐	
Female – Planning pregnancy	☐	☐	
Females – Menopause	☐	☐	
Sexually Transmitted Disease	☐	☐	
MUSCULOSKELETAL			
Joint Pain	☐	☐	
Muscle Pain	☐	☐	
Muscle Weakness	☐	☐	
Joint Stiffness/Cramping	☐	☐	
Gout	☐	☐	
Arthritis	☐	☐	
SKIN/BREAST			
Rash or Itching	☐	☐	
Change in Skin Color	☐	☐	
Change in Hair/Nail Color	☐	☐	
Varicose Veins	☐	☐	
Breast Pain	☐	☐	
Female – Breast Discharge	☐	☐	
NEUROLOGICAL			
Stroke	☐	☐	
Frequent Headaches	☐	☐	
Lightheadedness/Dizziness	☐	☐	
Seizures	☐	☐	
Numbness/Tingling	☐	☐	
Tremors	☐	☐	
Head injury	☐	☐	
Blackout/Loss of Consciousness	☐	☐	
PSYCHIATRIC			
Nervousness	☐	☐	
Depression	☐	☐	
Insomnia	☐	☐	
ENDOCRINE			
Hormone Problem	☐	☐	
Thyroid Disease	☐	☐	
Diabetes	☐	☐	
Excessive Thirst	☐	☐	
Excessive Urination	☐	☐	
Heat/Cold Intolerance	☐	☐	
Dry Skin	☐	☐	
HEMATOLOGY/LYMPHATIC			
Slow to Heal After Cuts	☐	☐	
Bleeding or Bruising Tendency	☐	☐	
Anemia	☐	☐	
Past Transfusions	☐	☐	
Enlarged Glands	☐	☐	
Jaundice	☐	☐	
Hepatitis	☐	☐	
ALLERGIC/IMMUNOLOGIC			
Food Allergies	☐	☐	
Environmental Allergies	☐	☐	
Latex Allergies	☐	☐	

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____

MOORESVILLE PPM, LLC

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_____

Physician Signature

_____

Date

Mooresville PPM, LLC
E-Prescribing/Medication History Download Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically sent prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-prescribing program. These include:

- **Formulary and benefit transactions- gives the prescriber information about which drugs are covered by the drug benefit plan.**
- **Medication history transactions- provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.**
- **Fill status notification- allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, or partially filled.**

By signing this consent form you are agreeing that Mooresville PPM, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Mooresville PPM, LLC to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name **DOB**

_____ _____

Signature of Patient/Guardian **Date**

_____

Relationship to Patient

Mooresville Family Practice

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from: Mooresville Family Practice

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE: (Practice Representative)

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement form in the individual's records.