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: ____________________

Patient Name ______________________ Birth date ______________
Form Completed By ______________________ Chart Number ______________
Date ______________________ Nurse Initials ______________

Household

Please list everyone living in the child's home

Name	Relationship to Child	DOB	Health Problems

Birth History

Birth weight______________ APGAR________ /________ Was the delivery ☐ Vaginal ☐ C-section
If C-section, why?______________________

Was the baby born at term?____________ Early?_____ Late?_____

If early, how many weeks gestation?______________ Did the baby have any problems right after birth?
☐ Yes ☐ No Explain______________________

Did mother have any problem with her pregnancy?
☐ Yes ☐ No Explain______________________

Was initial feeding ☐ Breast ☐ Bottle

During pregnancy, did mother
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No
What______________ When______________

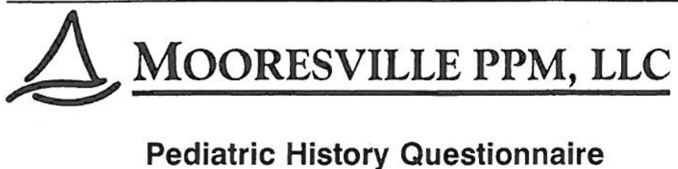
Did your baby go home with mother from hospital?
☐ Yes ☐ No Explain______________________

General

Do you consider your child to be in poor health? ☐ Yes ☐ No Explain ______________
Does your child have a serious medical condition? ☐ Yes ☐ No Explain ______________
Has your child had significant injuries/accidents? ☐ Yes ☐ No Explain ______________
Has your child had any surgery? ☐ Yes ☐ No Explain ______________
Has your child ever been hospitalized? ☐ Yes ☐ No Explain ______________
Is your child allergic to any medications? ☐ Yes ☐ No Explain ______________
Does your child take any regular medications? ☐ Yes ☐ No Explain ______________

Development

When did your child: Sit up _____ mos. Crawl _____ mos. Walk _____ mos. First sentence _________ Toilet trained _________
Are you concerned about your child's physical development? ☐ Yes ☐ No Explain______________
Are you concerned about your child's mental development? ☐ Yes ☐ No Explain______________
Are you concerned about your child's attention span? ☐ Yes ☐ No Explain______________
How is your child's behavior in school? ______________________
Has he/she failed or repeated a grade? ______________________
What kind of grades does he/she make in academic subjects? ______________________
Is he/she in a special or resource classes? ______________________



Pediatric History Questionnaire

73839 (10/09)

____
Physician Signature

____
Date

Family History

Have family members (Patient's mother, father, sister, brother, aunt, uncle, grandfather, grandmother) had the following:

Condition	Yes	No	Who/Explain
Significant allergies	☐ Yes	☐ No	Who/Explain ____
Asthma	☐ Yes	☐ No	Who/Explain ____
Deafness	☐ Yes	☐ No	Who/Explain ____
Tuberculosis	☐ Yes	☐ No	Who/Explain ____
Heart disease (onset before age 50 yrs.)	☐ Yes	☐ No	Who/Explain ____
High blood pressure (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain ____
Stroke (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain ____
Diabetes (before age 50 yrs.)	☐ Yes	☐ No	Who/Explain ____
High cholesterol	☐ Yes	☐ No	Who/Explain ____
Anemia, leukemia, free bleeding	☐ Yes	☐ No	Who/Explain ____
Liver disease	☐ Yes	☐ No	Who/Explain ____
Convulsions or seizures	☐ Yes	☐ No	Who/Explain ____
Migraine	☐ Yes	☐ No	Who/Explain ____
ADHD/learning disability	☐ Yes	☐ No	Who/Explain ____
Mental illness/suicide	☐ Yes	☐ No	Who/Explain ____
Mental retardation	☐ Yes	☐ No	Who/Explain ____
Immune deficiency/HIV/AIDS	☐ Yes	☐ No	Who/Explain ____

Review of Systems

Does your child have, or has he/she ever had: (If "Yes" please explain)

Condition	Yes	No	Explain
Chickenpox	☐ Yes	☐ No	Explain ____
Frequent ear infections	☐ Yes	☐ No	Explain ____
Problems with ears or hearing	☐ Yes	☐ No	Explain ____
Allergies	☐ Yes	☐ No	Explain ____
Problem with eyes or vision	☐ Yes	☐ No	Explain ____
Asthma, wheezing, bronchiolitis	☐ Yes	☐ No	Explain ____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain ____
Anemia or bleeding problem	☐ Yes	☐ No	Explain ____
Blood transfusion	☐ Yes	☐ No	Explain ____
Severe abdominal pain	☐ Yes	☐ No	Explain ____
Recurrent vomiting	☐ Yes	☐ No	Explain ____
Chronic diarrhea	☐ Yes	☐ No	Explain ____
Constipation requiring office visits	☐ Yes	☐ No	Explain ____
Bladder, kidney or urinary tract infections	☐ Yes	☐ No	Explain ____
Bed-wetting after 5 years old	☐ Yes	☐ No	Explain ____
(For girls) Has she started her menstrual period	☐ Yes	☐ No	Explain ____
(For girls) Are there any problems with periods	☐ Yes	☐ No	Explain ____
Any chronic or recurring skin problems	☐ Yes	☐ No	Explain ____
Severe headache	☐ Yes	☐ No	Explain ____
Convulsions, seizures, or concussions	☐ Yes	☐ No	Explain ____
Thyroid or gland problem	☐ Yes	☐ No	Explain ____

☐ Updated ____ Initials ____ ☐ Updated ____ Initials ____
☐ Updated ____ Initials ____ ☐ Updated ____ Initials ____
☐ Updated ____ Initials ____ ☐ Updated ____ Initials ____

MOORESVILLE PPM, LLC

Pediatric History Questionnaire

73839 (10/09)

____
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.