Wilson Family Medicine

Vicki Erwin-Wilson, M.D.
Les Wilson, M.D.

www.Wilsonfamilymedicine.com

2621 Mitcham Dr., Unit 103
Tallahassee, FL 32308
(850) 219-CARE (2273)

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Date: ____ /____ /____

Patient Name: ______________________ (Patient likes to be called): ______________________

Address (Physical location): ______________________ City: __________ State: ______ Zip: ________

Address (Mailing): ______________________ City: __________ State: ______ Zip: ________

Phone (Home): ____________ (Work): ____________ Ext: ______ Other (Bpr./Cell): ____________

Sex: Male / Female Birthdate: ____/____/____ Age: ________ Marital Status: S M D W

Patient's SS #: ______ – _____ – ________ Employer: ______________________

Employer's Address: ______________________

Emergency Contact: ______________________ Relationship: ____________ Phone: ____________

Referred By: ____________ Prev. Doctor: ____________ Reason for Changing Doctors: ____________

Name of Spouse: ______________________ Birthdate: ____/____/____

Names / DOB of Children: ______________________

____

____

GUARANTOR **(Who is Responsible for Payment)**

Name: ______________________

Address: ______________________ Apt #: ____________

City: ______________________ State: ____________ Zip: ____________

Phone (H): ______________________ (W): ______________________ Ext: ____________

Guarantor's SS #: ______ – _____ – ________

FOR CHILDREN

MOTHER'S NAME: ______________________ Birthdate: ____ /____ /____

Employer: ______________________ Phone: ____________

Home Address: ______________________ Home Phone: ____________

Mother's SS #: ______ – _____ – ________

FATHER'S NAME: ______________________ Birthdate: ____ /____ /____

Employer: ______________________ Phone: ____________

Home Address: ______________________ Home Phone: ____________

Father's SS #: ______ – _____ – ________

INSURANCE INFORMATION

PRIMARY INSURANCE: ______________________

Type Ins: ___ HMO ___ PPO ___ Other Co-Pay: $__________ Deductible: $__________

Insured's Name: ______________________ Relationship to patient: ____________

Phone (H): ______________________ (W): ______________________ Ext: ____________

Insured's SS #: ______ – _____ – ________ Employer: ______________________

Policy / Contract #: ______________________ Group #: ____________

Address to Mail Claims: ______________________

SECONDARY INSURANCE: ______________________

Type Ins: ___ HMO ___ PPO ___ Other Co-Pay: $__________ Deductible: $__________

Insured's Name: ______________________ Relationship to patient: ____________

Phone (H): ______________________ (W): ______________________ Ext: ____________

Insured's SS #: ______ – _____ – ________ Employer: ______________________

Policy / Contract #: ______________________ Group #: ____________

Address to Mail Claims: ______________________

SPECIAL ASSIGNMENTS / AUTHORIZATIONS (*Please Read Carefully*)

CONSENT TO TREATMENT

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all local anesthetic and/or blocks, and any and all medication and technical procedures which in the judgement of the Healthcare provider attending and consulting may be considered necessary or advisable to treat:

Me ______________________________ – OR – My ______________ / ______________________
(Print Name) (Relationship) (Print Name)

while a patient of a physician in the employment of Wilson Family Medicine.
In addition to the above:

- I consent to the appropriate disposal by Wilson Family Medicine of any specimens or other bodily materials removed during technical procedures or for testing purposes.
- I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the results of any therapies and/or procedure(s).

PATIENT'S VALUABLES

Wilson Family Medicine, LLC does not accept responsibility for any personal property (monetary or sentimental).

ASSIGNMENT OF INSURANCE BENEFITS

I hereby certify that the following information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to Wilson Family Medicine, LLC of all benefits due me under the terms of said policies and programs. I assign payment to the Physician(s) rendering medical services, the in-hospital based Specialist, and the Physician(s) for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance or any other charges incurred which are not paid by my insurance or other third-party payors together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

RELEASE OF INFORMATION

I do hereby authorize Wilson Family Medicine, LLC and any physician examining and/or treating me to release any medical information and records concerning diagnosis and treatment either during inpatient or outpatient treatment for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

HMO ELIGIBILITY GUARANTEE

I hereby certify that if I am enrolled in an HMO and/or MediPass that I am receiving healthcare services through the primary care physician that I have chosen or has been assigned to me. I understand that if the above is not true or if I am not eligible under the terms of my medical and hospital subscriber health insurance agreement, I am liable for all charges for the services rendered. Also, if the above is not true, I agree to pay in full for all services received within thirty (30) days of receiving a bill from Wilson Family Medicine, LLC.

My signature represents that I have read the above and thereby give my agreement and authorization to all of the above:

______________________________ ______________________________
Signature Date

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HISTORY

NAME ______________________ DATE ______________

DATE OF BIRTH ______________ OCCUPATION ______________________

PAST OCCUPATIONS ______________________________

Family History — If any blood relative has suffered any of the following, please indicate which relative:

- ❑ Alcoholism ______________
- ❑ Allergy ______________
- ❑ Arthritis ______________
- ❑ Asthma ______________
- ❑ Cancer ______________
- ❑ Diabetes ______________
- ❑ Epilepsy / Seizures ______________
- ❑ Glaucoma ______________
- ❑ Gout ______________
- ❑ Heart Attack ______________
- ❑ Hypertension ______________
- ❑ Kidney Disease ______________
- ❑ Mental Illness ______________
- ❑ Migraine ______________
- ❑ Stroke ______________
- ❑ Suicide ______________
- ❑ Tuberculosis ______________
- ❑ Other ______________

Hospitalizations — Please list the year and why you were hospitalized (include major surgeries):

Year	Illness or Operation	Year	Illness or Operation

Medical Illnesses — Please list any chronic medical illnesses and how long you have had them:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Medications — Please list all your medications and include nonprescription items such as cold medications, antacids, laxatives, vitamins and supplements:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Allergies — Please list any medications that you are allergic to:

____

____

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HISTORY

NAME ______________________________

IMMUNIZATIONS When was your last: flu shot? ______________ tetanus? ______________

pneumonia vaccination? ______________ other? ______________

SOCIAL HISTORY ☐ coffee / tea / sodas? __________ cups / day __________ ☐ tobacco? __________ packs / day __________

☐ alcohol? __________ amount / week __________ ☐ Sexually active? __________ # current partners __________

HEALTH MAINTENANCE What year was your last: eye exam? __________ complete physical? __________

sigmoidoscopy? __________

FOR WOMEN Pap smear? __________ Breast exam? __________ Mammogram? __________

CHILDHOOD ILLNESSES Check all illnesses that you have had:

☐ Chicken Pox ☐ Measles ☐ German Measles ☐ Mumps ☐ Scarlet Fever

☐ Rheumatic Fever ☐ Tuberculosis ☐ Whooping Cough ☐ Other __________

WHAT ARE YOU HERE TO SEE THE DOCTOR FOR TODAY? ______________________________

____

Check (✓) "YES" for each applicable item. (*If "YES", indicate whether Past or Present.*)

	CONDITIONS	YES	PAST	PRESENT
GENERAL	Fever			
	Weight Change			
	Bruise Easily / Bleeding Problems			
	Swollen Glands			
	General Weakness			
	Aches / Pains			
	Blood Transfusion			
HEAD / NECK	Vision Change			
	Ear Pains			
	Buzzing / Ringing in Ears			
	Sinus Problems			
	Swallowing Problems			
	Decreased Hearing			
	Mouth, Tooth or Tongue Problems			
	Persistent Hoarseness			
	Severe Headaches			
SKIN	Rash / Hives			
	Changing Moles			
	Skin Cancer			
	Other Skin Problems			
CHEST / HEART / LUNGS	Irregular Heartbeat			
	Shortness of Breath			
	Low Exercise Tolerance			
	Chest Pains			
	Frequent Coughs			
	Cough up Blood			
	Wheezing			
	Swollen ankles			
	Exposure to TB			
	High Blood Pressure			

	CONDITIONS	YES	PAST	PRESENT
GASTROINTESTINAL	Indigestion / Heartburn			
	Nausea			
	Vomiting Blood			
	Abdominal Pain or Cramps			
	Diarrhea or Constipation			
	Bowel Habit Changes			
	Rectum Blood Passage			
	Black Tar-Type Bowel Movements			
	Hernia			
	Hepatitis / Jaundice			
KIDNEY	Up Nights to Urinate (more than 2 times)			
	Blood in Urine			
	Burning or Pain While Urinating			
	Problem Passing Urine			
	Trouble Controlling Urine			
	Kidney Stones			
NEUROMUS	Leg or Arm Weakness			
	Balance Problems / Dizziness			
	Fainting Spells			
	Convulsions / Seizures			
	Memory Loss			
BONES / JOINTS	Joint Pains			
	Joint Swelling			
	Muscle Strength Loss			
	Gout			
	Pains in Back			
	Phlebitis			
	Leg Cramps			

	CONDITIONS	YES	PAST	PRESENT
PSYCHOLOGICAL	Is Your Life Satisfactory			
	Do You Have a History of:			
	Anxiety			
	Depression			
	Bipolar Illness			
	Have You Seriously Considered Suicide			
MEN	Lump in Testicles			
	Penis Discharge or Sore			
	Sexually Transmitted Disease			
	Sexual Concern			
WOMEN	Breast Lump			
	Unusual Nipple Discharge			
	Unusual Vaginal Discharge			
	Hot Flashes			
	Change in Periods			
	Sexually Transmitted Disease			
	Abnormal Pap Smear			
	Bloating, Irritability with Periods			
	Sexual Concern			

FEMALES — MENSTRUAL HISTORY

Age of onset menses __________

Pregnancies __________

Births __________

Miscarriages __________

Birth Control Method __________

Age of Menopause __________

Last Menstrual Period __________

Regular: ☐ YES ☐ NO

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- obtain payment from third-party payers; and
- conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ____________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason: