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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PEDIATRIC HISTORY

NAME: _____ AGE: _____ DOB: _____ TODAY'S DATE: _____

ADDRESS: _____ PARENTS' NAMES: _____

_____ _____

PHONE: _____ LEGAL GUARDIAN: _____

MEDICAL PROBLEMS:	MEDICATIONS:	HOSPITALIZATIONS / SURGERIES / DATE:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

BIRTH HISTORY:

1. Problems with mother's pregnancy?
2. Birth Weight
3. Did mother smoke or drink alcohol during pregnancy?
4. Did mother take any medications during pregnancy?
5. Did mother use any recreational drugs in pregnancy?
6. How many weeks pregnant was mother when baby was born?
7. Any problems during labor or delivery?
8. Was the baby delivered by c-section or vaginally?
9. Any problems during the nursery stay?
10. How long did baby stay in hospital? mother?
11. Any problems for baby or mother within 2 months of birth? If so, what?

FEEDING / NUTRITION:

1. Any unusual feeding problems?
2. Any problem with diarrhea or constipation?
3. Is the child's drinking water city or well water?
4. Is the water fluoridated?
5. How many meals does the child eat per day? How many snacks?
6. Does the child take vitamins? fluoride? iron?
7. Was (is) the child breastfed? how long?
8. What type (if any) infant formula used?
9. What age was bottle discontinued?
10. At what age did baby eat first solid food?
11. Does (did) baby have a pacifier?

ALLERGIES (list any allergies child has, including any allergic reactions to medications)

IMMUNIZATIONS: Is child up to date? (Please supply record of any previous immunizations)

CHILD CARE / SCHOOL: Is child in school or a day care center? Where?

If not, who is (are) child's primary caretaker(s) during the day? In the evenings? Weekends?

MEDICAL / FAMILY HISTORY (please mark if child or members of the child's family — parents, siblings, grandparents, aunts, uncles — have had any of the following illnesses or problems.

	child	family		child	family
1. frequent ear infection			13. kidney / bladder problems		
2. frequent colds, sore throats			14. seizures / convulsions		
3. croup			15. early heart disease (age <65)		
4. mumps, measles, chicken pox			16. high blood pressure		
5. wheezing or asthma			17. high cholesterol		
6. pneumonia			18. lung disease / tuberculosis		
7. eye problems			19. sexually transmitted disease		
8. dental problems			20. alcohol / drug abuse		
9. hearing problems			21. emotional problems / suicide attempts		
10. hayfever			22. cancer		
11. eczema / skin problems			23. other illnesses (list)		
12. anemia / blood problems					

PEDIATRIC HISTORY *(continued)*

NAME:_____ DOB: _____

DEVELOPMENT AND BEHAVIOR:

1. Did child sit alone by 7 months?
2. Did the child walk alone by 14 months?
3. Did the child say 3 words by 15 months?
4. Is the child doing well in school?
5. Does the child get along well with other children?
6. Check off any of the following problems the child has:
   a. Nightmares / sleep problems
   b. Irritable / bad temper
   c. discipline problem
   d. speech problem
   e. thumbsucking
   f. bedwetting
   g. toilet training problems
   h. breath holding

HEALTH AND SAFETY:

1. Are there guns in the child's house?
2. How often does the child use a toothbrush?
3. Does the child always use a car seat or seatbelt?
4. Are there smoke detectors in the child's home?
5. Is the hot water heater set less than 125 degrees?
6. Do you have rules / limits for television viewing?
7. Are medicines and poisons out of reach?
8. Do you have syrup of Ipecac?
9. Do all of child's caretakers know child resuscitation or choking management?
10. Is there a pool or other body of water at or near child's home? Can child swim?
11. Does child wear a bicycle helmet?

SOCIAL HISTORY:

1. Please list all household members, ages, relationship to child, and general health:

Name	Age	Relationship	General Health

2. Please list any family members not living in the same household as the child:

Name	Age	Relationship	General Health

3. Parents' and / or guardians' education and occupations:

4. Has the child ever experienced any traumatic event, such as loss of a loved one, divorce, serious accident, etc.?

5. What activities does the child particularly enjoy?

6. What activities does the child particularly dislike?

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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: