Clark-Brown
Family Care Clinic

Registration

Last name

_____

First name

_____

Middle name

_____

Sex
M F

DOB
___ / ___ / _____

Social Security Number

____ - ____ - _____

Address

_____

City _____ State _____ ZIP code _____

Work phone _____ - _____ - _____

Home phone _____ - _____ - _____

Cell phone _____ - _____ - _____

Email address

_____

Contact preference

Work Home Cell

Marital status

Married Single Divorced Separated Widowed Partner

Guardian

Last name

_____

First name

_____

Emergency Contact

Name

_____

Relationship

_____

Phone number _____ - _____ - _____

Insurance

Insurance name

_____

ID _____ Group number _____

Guarantor

Last name

_____

First name

_____

DOB ___ / ___ / _____

Relationship to patient

_____

Secondary insurance name

_____

ID _____ Group number _____

Guarantor

Last name

_____

First name

_____

DOB ___ / ___ / _____

Relationship to patient

_____

In order to establish optimal relations with our patients in regard to our payment policies, **PAYMENT IS EXPECTED AT TIME OF SERVICE** for "Your Part" of the charges. The Adult/Guardian who brings in a minor will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. Your signature below indicates that you understand and accept this policy. You herein authorize payment of medical benefits to Dr. Cheryl Clark-Brown when an assigned claim is filed. This signature also indicates that you are aware of your HIPAA rights; a copy is available upon request.

Signature Date

_____

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Medical History

Preferred pharmacy name

_____

Address

_____

City State ZIP code

_____ _____ _____

Phone number _____ - _____ - _____

Allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current medications

_____

_____

_____

_____

_____

_____

_____

_____

Smoker

Yes No Never Former

Please list any vaccines received after the age of 18 along with vaccination dates if possible.

_____

_____

_____

_____

Most Recent

Physical Exam _____

Colonoscopy _____

Mammogram _____

Pap smear _____

Surgical History

Surgery Date

_____

_____

_____

_____

_____

Patient's Care Team

Please list the name, specialty, and phone number of your current providers/physicians.

_____

_____

_____

_____

_____

_____

_____

Personal Past Medical History

Please circle **Yes** or **No** below…

ADHD	**Yes**	**No**
AIDS/HIV	**Yes**	**No**
Abuse/Domestic violence	**Yes**	**No**
Allergies	**Yes**	**No**
Anemia	**Yes**	**No**
Anesthesia complications	**Yes**	**No**
Anxiety	**Yes**	**No**
Arthritis	**Yes**	**No**
Asthma	**Yes**	**No**
Autism Spectrum Disorder	**Yes**	**No**
Bedwetting	**Yes**	**No**
Birth defects or inherited disease	**Yes**	**No**
Bladder &/or kidney problems	**Yes**	**No**
Blood diseases	**Yes**	**No**
Blood transfusions	**Yes**	**No**
Breast Cancer	**Yes**	**No**

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Breast problems	Yes	No
COPD	Yes	No
Cancer	Yes	No
Chicken Pox	Yes	No
Chronic ear infections	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Constipation	Yes	No
Coronary Artery Disease	Yes	No
Depression	Yes	No
Developmental or Behavioral Disorders	Yes	No
Diabetes	Yes	No
Difficulty swallowing	Yes	No
Diverticulitis	Yes	No
Ear or Hearing problems	Yes	No
Eating disorders	Yes	No
Eczema	Yes	No
Endometriosis	Yes	No
Fibromyalgia	Yes	No
GI problems	Yes	No
Gout	Yes	No
Headaches	Yes	No
Heart Disease	Yes	No
Hepatitis	Yes	No
High Cholesterol	Yes	No
Hospitalizations	Yes	No
Hypertension	Yes	No
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No
Infertility	Yes	No
Kidney Disease	Yes	No
Kidney stones	Yes	No
Liver Disease	Yes	No
Lung Disease	Yes	No
Meniere's disease	Yes	No

Mental Disorder	Yes	No
Mental Illness	Yes	No
Muscle, Joint, or Bone problems	Yes	No
Nasal polyps	Yes	No
Obesity	Yes	No
Osteoporosis	Yes	No
Other	Yes	No
Ovarian Cancer	Yes	No
Polyps	Yes	No
Pre-Eclampsia	Yes	No
Pulmonary Embolism	Yes	No
Acid Reflux/GERD	Yes	No
Seizures/Epilepsy	Yes	No
Skin problems	Yes	No
Stroke	Yes	No
Thrombophilia	Yes	No
Thyroid problems	Yes	No
Tuberculosis	Yes	No
Varicosities	Yes	No
Vision or Eye problems	Yes	No
MRSA exposure	Yes	No

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Family History

☐ Unknown

Relation	Diagnosis	Onset age	Died of Age
Mother			
Father			
Brother			
Sister			
Son			
Daughter			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Unspecified Relation			

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HIPAA Form

Our Notice of Privacy Practices provides information about how we **Clark-Brown Family Care Clinic** may use or disclose protected health information. This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? yes no

May we leave a message on your answering machine at home or on your cell phone? yes no

May we discuss your medical condition with any member of your family? yes no

If YES, please name the member(s) allowed:

Name: _____ Relation:_____

Contact phone#: _____

This consent is signed by (PRINT NAME): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Prescription Policy

Prescriptions for medications and authorizations for refills MUST be requested during normal office hours Prescription refills will not be reviewed if requested after hours or on weekends. Therefor, patients must anticipate their need for medication and contact their pharmacy first to request ether a fax or electronic refill request. Due to large volume of phone messages; it may not be possible for office staff to call medications on the same day. Please allow 24 business hours for all prescription requests to be approved. Thank you for your understanding

_____

Print patient name

_____

Signature of patient or legal guardian

____ / ____ / _____

Date