Patient Registration Form

PATIENT NAME:____() MALE () FEMALE
BIRTH DATE:_______________AGE__________SOCIAL SECURITY NUMBER____-____-______
ADDRESS:____ APT #__________________
CITY:_ ______________________________STATE:_____________ ZIP:_______________________
HOME PHONE:____-____-______WORK PHONE: ____-_____-______CELL: ___-_____-______
EMPLOYED () YES () NO EMPLOYER NAME:______________________________________
MARITAL STATUS: () SINGLE () MARRIED () DIVORCED () WIDOWED
GUARANTOR NAME (if other than patient)_____________________________________
FORMER PRIMARY CARE PHYSICIAN:____

INSURANCE INFORMATION: WE REQUIRE YOUR CARD TO BE PRESENTED AT EVERY VISIT.
PRIMARY INSURANCE COMPANY:________________________________ CO-PAY____________
CARDHOLDER NAME:________________________________ DATE OF BIRTH:_______________
ADDRESS:____

SOCIAL SECURITY NUMBER:_____-_____-______
RELATIONSHIP TO PATIENT: () SELF () SPOUSE () PARENT () OTHER
SECONDARY INSURANCE COMPANY:____
CARDHOLDER NAME:____DATE OF BIRTH:__________
ADDRESS:______________________________________ ______________________________

I hereby authorize **Westland Family Care, LLC** to release any information in connection with my claim to the above named insurance carriers, the social security administration or their intermediaries or carriers. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits be made directly to Westland Family care, LLC

Patient or responsible party Signature:______________________________________Date:______________

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected at the time of check –in.

We accept payment in the form of cash, check and credit card. Returned checks will be subject to a **$30.00 return fee**. It is your responsibility to verify our participation with your plan and any ancillary providers prior to your visit. You must give at least 24 hour notice if you are unable to keep an appointment. You may be charged a **$50.00 fee for missed appointments**.

Patient or responsible party Signature: ____________________________ _________Date:_______________

MEDICAL HISTORY

PATIENT NAME:________________ SOCIAL SECURITY NUMBER___-__-____ MALE__ FEMALE__

Medical History:

1. If you have had or are subject to any of the conditions listed below, please check the appropriate one and list your age when the condition occurred.

__Anemia________________ __Hay Fever__________________ __Scarlet Fever__________
__Anxiety________ _______ __ High Blood Pressure_____ ____ __Sinus Trouble__________
__Arthritis_______________ __Heart Trouble_______________ __ Skin Disease___________
__Asthma_______________ __Hemophilia_________ ________ __Stuttering_____________
__Bed Wetting____________ __Hepatitis___________________ __Swollen Joints__________
__Bloody Urine_______ ____ __Jaundice____________________ __ Thyroid Problems______
__Broken Bones__________ __Kidney Trouble______________ __ Tonsillitis_____________
__Cancer________________ __Liver Problems______________ __ Tuberculosis___________
__Convulsions____________ __Malaria_____________________ __Typhoid Fever_________
__Chicken Pox____________ __Measles_____________________ __Ulcers_________________
__Colitis_________________ __Menstrual Disorders________ __ __Urinary Frequency_______
__Depression_____________ __ Mumps______________________ __Venereal Disease_______
__Diphtheria_____________ __Pleurisy_____________________ __Fainting Spells_________
__ Pneumonia____________ __ Frequent Headaches__________ __Poliomyelitis__________
__Gout__________________ __Rheumatic Fever__________ __ __Other__________________

2. If you have a family history of any of the following conditions, please check where appropriate and indicate the person afflicted. Includes parents, grandparents, siblings.

__Arthritis______________ _ __Emphysema______________ __Number of Sisters___________
__ Blood Disease_______ __Heart disease______________ __ Number of Brothers__________
__Cancer______________ __High Blood Pressure____
__ Diabetes____________ __ Nervous Disorder____
__Epilepsy____________ __Tuberculosis____

MARITAL STATUS: __Single __Married __Divorced __Widowed

3. Allergies:____

4. Habits: ____ Smoke ___Packs/day ___Alcohol per week ___Coffee or POP per day

___ Street drug abuse what kind____

5. Check if any of the following apply to you, give the date and condition.

__Last hospitalization____

__All Surgeries, last one first____

____

6. Menstrual History: Onset____ _How many pregnancies______ How many living children______

LMP______ Miscarriages___________ Regular Periods___ Yes ___No

Signature____ Date______________________________

WESTLAND FAMILY CARE, LLC 100 North Murray Hill Road Columbus, OH 43228

MEDICAL HISTORY

Initial:_______ **NT NAME:____** **DOB:____________________**

• Westland Family Care requires 24 business hours (Monday-Friday) notice for appointment cancellations. Otherwise the patient may be charged up to the full fee of the appointment. For example: if the patient's appointment is Monday at 9:00am Westland Family Care must receive a call by 9:00am the previous Friday to have given proper 24 business hours' notice.

Initial:_______

•First appointments scheduled with the physician require 48 business hours notice for appointment cancellations/rescheduling. If Westland Family Care is *not* provided 48 business hours notice, the appointment may not be rescheduled.

Initial:_______

•It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls as a courtesy will be made a day prior to the appointment.

Initial:_______

•The office will verify the patient's medical health benefits; however, this is not a guarantee of payment. It is the patient's responsibility to know his/her benefits including deductibles and co-pays.

Initial:_______

•Insurance companies require payment of co-pays/coinsurance at the time of service.

Initial_______

•Please notify Westland Family Care in a timely manner of any changes, including: insurance coverage, address, and telephone number. Delay in providing us with accurate information may prevent insurance reimbursement, and the patient will be responsible for the fees.

Initial_______

•Westland Family Care submits claims only to the insurance companies with whom we are contracted with.

Initial_______

•Westland Family Care will not submit claims to secondary insurances with the exception of Medicare supplemental plans.

Initial_______

•There will be a $30 charge for any returned checks. If there is a history of 2 returned checks, our office will only accept cash or credit card payments.

As a client of Westland Family Care I have read and understand the operating procedures, and hereby give permission to the professional staff at the agency to provide diagnostic and/or therapeutic services.

SIGNITURE:____ **DATE:________________________________**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I,____, have received access to a copy of Westland Family Care, LLC notice of privacy practices.

SIGNITURE.____ **DATE:________________________________**

MEDICAL HISTORY

HIPPA

KEEPING YOUR HEALTH INFORMATION PRIVATE

NAME:____ DATE OF BIRTH_____________

ADDRESS:____

SOCIAL SECURITY NUMBER: ________-______-________

HOME/DAYTIME CONTACT NUMBER:____

Do we have permission to call your home? () Yes ()No

Can we leave a message on your home answering machine? () Yes ()No

Do we have permission to call you at work? ()Yes ()No

To whom at your residence may we talk about your health care?
Name:________________________Relationship:__________________________________
Home #:______________________Cell phone:____________________________________

Please provide information on your emergency contact below:
Name:_______________________________ Relationship:______________________________
Home#: _____________________________ Cell phone:________________________________

IF ANY OF THE ABOVE INFORMATION CHANGES, IT IS THE PATIENT/PARENT/LEGAL GUARDIAN'S RESPONSIBILITY TO CONTACT OUR OFFICE.

Patient/Parent/Legal Guardian Signiture:____