MOREHOUSE COMMUNITY MEDICAL CENTERS, INC.

ADULT REGISTRATION FORM

Today's Date ____/____/____

PATIENT INFORMATION (Please give your driver's license to the receptionist)

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status Circle One Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name	Birth Date / /	Age	Sex ☐ M ☐ F

Work Status: ☐ Migrant Worker ☐ Seasonal Worker ☐ N/A

Veteran Status: ☐ I am a Veteran ☐ I am not a Veteran

Housing Status: ☐ Homeless ☐ Doubling Up ☐ Street ☐ Transitional ☐ N/A

Number of people living in your household:

Ethnicity (Check One): ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race (Check One):
☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race ☐ White ☐ Black/African American
☐ American Indian/Alaska Native ☐ Do not wish to disclose

Annual Household Income (if willing to report):
☐ Less than $10,000 ☐ $10,001-$20,000 ☐ $20,0001-$40,000
☐ $40,001 - $60,000 ☐ $60,0001-$100,000 ☐ $100,000+

PO Box	City	State	Zip Code	Social Security #	Home Phone No. ( )

Street Address	City	State	Zip Code

Occupation	Employer	Employer Address	Employer Phone No. ( )

Email address: Preferred contact method: ☐ Phone ☐ email ☐ mail

PARENT/GUARDIAN INFORMATION (To be completed if the patient is a minor)

Mother's/Guardian's Name	Mother's/Guardian's Birth Date / /	Mother's/Guardian's Social Security #	Home Phone No. ( )
Father's Name	Father's Birth Date / /	Father's Social Security #	Cell Phone No. ( )

Address (if different from above)

Person Responsible for Bill	Relationship to the Patient	Occupation

Employer	Employer Address	Employer Phone No. ( )

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Is this patient covered by insurance? ☐ Yes ☐ No
If Yes, please check one: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Other:

Name of Primary Insurance	Policyholder's Name	Policy #	Co-Payment $
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other		Policy holder's DOB:	
Name of Secondary Insurance	Policyholder's Name	Policy #	Co-Payment $
Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other		Policy holder's DOB:	

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	Cell Phone No. ( )

EMERGENCY CONTACT – If person above lives with you we also need:

Name of Local Friend or Relative (not living at same address as you)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	Cell Phone No. ( )

Name of person completing this form, if other than patient: _____

(Updated 2/17/12)

GENERAL QUESTIONS

Answering the following questions will help us determine what other services the clinic offers that you may qualify for:

Yes	No	
___	___	Do you have reliable transportation?
___	___	Do you have prescription drug coverage?
___	___	Do you currently qualify for any government programs such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment? If yes, please list_____
___	___	If you do not currently have Medicaid, have you ever applied for Medicaid? What was the outcome? _____

NOTICE OF PRIVACY PRACTICES

I have been provided with and understand the contents of the NOTICE OF PRIVACY PRACTICES for Morehouse Community Medical Centers, Inc. and its' entities. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Morehouse Community Medical Centers, Inc. and its' entities are not required to agree to the restrictions requested.

ASSIGNMENT AND RELEASE OF BENEFITS

PRIVATE INSURANCE: The undersigned assigns and hereby authorizes whether he/she signs as agent or as patient, direct payment to the clinic of all insurance and plan benefits otherwise payable to or on behalf of the patient for medical services. It is agreed that payment to the clinic pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

MEDIARE/MEDICAID: I certify that the information given by me in applying for payment under Title 18 of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that the payment of authorized benefits be made in my behalf. I assign payment for any unpaid charges for the clinic is authorized to bill in connection with its services. I understand that I am responsible for any remaining balance not covered by other insurance.

GENERAL OFFICE POLICIES

1. All co-pays and deductible amounts must be paid at the time of service unless other signed arrangements have been made.
2. All returned checks are subject to a $25.00 (or %5 of check, whichever is higher) service charge.
3. All delinquent accounts are automatically turned over to collection after 90 days if no response of payment is received.
4. All patients will be seen on a first come first serve basis or by scheduled appointments, although Morehouse Community Medical Centers, Inc., has the right to take patients with medical emergencies first.
5. This is a "SMOKE FREE" building. All smoking is prohibited.
6. No alcohol or drug use is allowed on the premises. Anyone abusing this policy will be asked to vacate the premises. If this request is not followed, Law Enforcement will be called.
7. No firearms/weapons are allowed on the premises. Law Enforcement will be called and said persons will be banned from any Morehouse Community Medical Centers, Inc., property.

I understand and agree to abide by the general office policies.

CONSENT FOR TREATMENT

I authorize Morehouse Community Medical Centers, Inc. and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as they determine necessary. I understand that my condition may call for a consultation with another Healthcare Provider. If this situation occurs, I authorize Morehouse Community Medical Centers, Inc. to release any medical information that may be needed to better provide for my medical treatment.

Patient's Signature (or Parent/Guardian's Signature): _____ Date: _____

Witness Signature _____

HEALTH HISTORY

Patient Name: _____ **DOB:** _____

SYMPTOMS: Please circle any of the following that apply to you:

General
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss of Weight
Nervousness
Numbness
Sweats

Cardiovascular
Chest pain
High blood pressure
Irregular heartbeat
Low blood pressure
Poor circulation
Rapid heartbeat
Swelling of ankles
Varicose veins

Gastrointestinal
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal Bleeding
Stomach pain
Vomiting
Vomiting blood

Men Only
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other _____

Eye, Ear, Nose, Throat
Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Vision- flashes
Vision- halos

Genito-Urinary
Frequent urination
Lack of bladder control
Painful urination

Muscle/Joint/Bone
Pain, weakness, numbness in:
Arms Hips
Back Neck
Feet Shoulders
Hands Legs

Skin
Bruise easily
Hives
Change in moles
Rash
Scars
Sore that won't heal
Where _____
Blood in urine

Women Only
Abnormal pap smear
Bleeding between periods
Breast lump
Extreme Menstrual Pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other _____
Last menstrual period
_____
Last pap smear
_____
Last mammogram
_____
Are you pregnant? _____
Number of children ____

MEDICATIONS: List any medications you are currently taking. (Over the counter or prescription).
_____
_____
MEDICATION ALLERGIES: _____

CONDITIONS: Please circle any of the following that you have or have had in the past:

AIDS	Bronchitis	Glaucoma	HIV Positive	Pacemaker	Thyroid Problems
Alcoholism	Bulimia	Goiter	Kidney Disease	Pneumonia	Tonsillitis
Anemia	Cancer	Gonorrhea	Liver Disease	Polio	Tuberculosis
Anorexia	Cataracts	Gout	Measles	Prostate Problem	Typhoid Fever
Appendicitis	Chemical Dependency	Heart Disease	Migraine Headaches	Psychiatric Care	Ulcers
Arthritis	Chicken Pox	Hepatitis	Miscarriage	Rheumatic Fever	Vaginal Infections
Asthma	Diabetes	Hernia	Mononucleosis	Scarlet Fever	Venereal Disease
Bleeding	Emphysema	Herpes	Multiple Sclerosis	Stroke	
Breast Lump	Epilepsy	High Cholesterol	Mumps	Suicide Attempt	

FAMILY HISTORY: Check if any blood relatives have had any of the following:

	Disease	Relationship
_____	Arthritis, Gout	_____
_____	Asthma, Hay Fever	_____
_____	Cancer	_____
_____	Chemical Dependant	_____
_____	Diabetes	_____
_____	Heart Disease, Stroke	_____
_____	High Blood Pressure	_____
_____	Kidney Disease	_____
_____	Tuberculosis	_____
	Other_____	_____

HOSPITALIZATIONS:

Year	Hospital	Reason and Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion? (dates)_____

HEALTH HABITS: Check which substances you use and describe how much you use.
__ Caffeine _____ __ Tobacco _____ ___Alcohol _____

OCCUPATIONAL CONCERNS: Check if your work exposes you to the following:
___ Stress ___ Hazardous Substances ___ Heavy Lifting ___ Other Your Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold Morehouse Community Medical Centers, Inc. or any of its employees responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date_____