Access Family Practice and Walk-in Clinic
2324 N. Rolling Road, Windsor Mill, MD 21244
**Phone (410) 298-1931, Fax (410) 298-1932**
**Hours Mon - Fri 8:30 A.M. – 5 P.M. Sat -9 A.M. – 1 P.M. Sun -Closed**

# Patient Registration

Patient Last Name: _____

Patient First Name: _____ M.I. _____

Social Security No. : _____- ___ -_____ Date of Birth ____-___-_____

Gender: __ Male __ Female Marital Status: __ Single __ Married __ Other

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work: _____
Cell Phone: _____ Email: (optional) _____
Patient Employer: _____
Primary Care Physician: _____
Emergency Contact: Name_____ Phone_____
Relation: _____ Home/Cell/Work

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***Please fill out this portion if you are the patient's parent/guarantor/or if you are not the policy holder. Be sure to answer all questions. (Respond "see above" where applicable).***

Policy Holder's Name: _____
Last Name First Name M.I.
Policy Holder's Address: _____
City: _____ State: ____ Zip: _____
Policy Holder's Phone: _____
Date of Birth: ____-___-_____ Gender: ____ Male ____ Female
Relationship to Patient: ____ Parent ____ Spouse ____ Other: _____
Insurance Company Name:_____
Policy Number:_____
Policy Group Number: _____

*By signing below, I authorize use of this form on all my insurance submissions and release of information to my insurance carrier. I further authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier. This payment is to be made directly to my doctor. Finally, I permit a copy of this authorization to be used in place of the original and in place of my signature on my insurance forms. Financial Responsibility: This information is accurate and true to the best of my knowledge. I understand I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default.*

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**Signature: _____ Date: _____**

Where did you hear about Access Family Clinic? __Yahoo __Google __Super Pages
__Friend __Letter __Mailer __Newspaper __Other_____
__Work __Radio __Relative __Signage __Phone Book __Health Dept.

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# Patient Medical History

Patient's Name: (Last) _____ (First) _____ (M.I.)_____

Are you currently being treated for anything? ..... Yes No

If yes, explain _____

Have you ever undergone a surgical procedure? ..... Yes No

If yes, please state the nature of the surgery and the approximate date performed:
_____

When did you have your last physical exam? _____

Physician's Name and Telephone No: _____

Name of Pharmacy you use and Telephone No: _____

Have you ever had, or do you now have any of the following? (Check if Yes)
__ Heart (Surgery, Disease, Attack) __ Blood Transfusion __ HIV Positive / AIDS
__ High Blood Pressure __ Bruise Easily __ Stroke
__ Chest Pain __ Hemophilia __ Seizures
__ Heart Murmur __ Anemia __ Neurological
__ Mitral Valve Prolapse __ Venereal Disease Disorder
__ Artificial Heart Valve __ Syphilis __ Hepatitis A,B,C,D,G
__ Rheumatic Fever __ Herpes __ Cirrhosis
__ Artificial Joints __ Migraines __ Cancer
__ Osteoporosis __ Depression
__ Active Tuberculosis __ Allergies or Hives __ Radiation Therapy
__ Bloody Cough __ Latex Allergy __ Chemotherapy
__ Asthma __ Sinus Trouble __ Women: Pregnant
__ Emphysema / COPD __ Weight Loss __ Women: Nursing
__ Arthritis/Rheumatism __ Tobacco Products __ Women: BC Pills
__ TMJ Disorder __ Alcohol Use __
__ Diabetes __ Drug Use __
__ Thyroid Problems __ Kidney Trouble __
__ Stomach Disorder __ Ulcers
**Family History**: __ Diabetes __ Hypertension __Heart __ other _____
Are you currently taking any **medications**?..... Yes No
If yes, please list medications: _____
Are you **allergic** to any medications? ___ No Known Allergies
__ Penicillin __ Codeine __ Aspirin __ Sulfa __Other:_____
If you are allergic to or have an adverse reaction to any other medications, please explain here:
_____
Do you smoke?..... Yes No
Please Specify: __ Cigarettes __ Pipes __ Cigars __ Other

***Signature:***_____ ***Date:*** _____

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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND FINANCIAL INFORMATION (VERBAL AND COPIES TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS.** In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your provider or the staff of Access Family Clinic to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.
**__I DO __DO NOT,** Authorize Access Family Clinic to release any and all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals.

_____ _____ _____
Name (please print) Relationship Phone Number

_____ _____
Your signature Date

**We must obtain your authorization** to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents
**I AUTHORIZE** Access Family Clinic to verbally discuss financial information with:
Name Relationship Phone Number

_____ _____
Your signature Date

**RECEIPT OF HIPAA PRIVACY NOTICE**
I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Access Family Clinic may use and disclose my protected health information. I understand that Access Family Clinic reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____
Printed Patient Name Date

_____
Signature of Patient or Parent/Guardian

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**Office Use Only: To be completed only when patient declines to sign acknowledgment**
__Check here if patient declined to sign acknowledgment _____
Staff signature & date
**Refusal to sign acknowledgment does not prevent the patient from continuing to be treated**
Please note that this is to be filed in the patient's record.