NORTH BAY FAMILY MEDICAL CLINIC

15012 LeMoyne Blvd. • Biloxi, MS 39532 • Telephone (228) 392-5050

Office Registration Form (Please Print)

PATIENT INFORMATION **Date** _____

Name of Patient _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Home Address _____
(STREET ADDRESS) (APT #) (CITY) (STATE) (ZIP CODE)

Mailing Address _____

Email Address _____

Date of Birth _____ Age _____ Sex _____ Single ____ Married ____ Divorced ____

Race: White ____ Black/African American ____ Asian ____ Other _____

Patient's Social Security Number _____

Home Phone No. _____ Cell Phone No. _____

Patient's Employer _____

Employer's Address _____
(STREET ADDRESS) (APT #) (CITY) (STATE) (ZIP CODE)

Employer's Phone No. _____

Nearest Relative or Friend _____ Phone # _____

Relationship to Patient _____

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Father's Name _____ Father's Employer _____

Father's Employer Address _____

Father's Work Phone _____ Father's S.S.# _____ Father's D.O.B. _____

Mother's Name _____ Mother's Employer _____

Mother's Employer Address _____

Mother's Work Phone _____ Mother's S.S.# _____ Mother's D.O.B. _____

Are Child's Parents (as listed above): Married _____ Divorced _____ Separated _____

SPOUSE INFORMATION

Husband or Wife's Name _____ Employer _____

Employer Address _____ Employer Phone _____

Husband's or Wife's S.S.# _____ Husband or Wife's D.O.B. _____

NORTH BAY FAMILY MEDICAL CLINIC

INSURANCE

Please check with our receptionist to see if we participate with your insurance group. We will need to copy your insurance cards in order to verify this.

Primary Insurance Company _____

lnsured's Name _____ S.S.# _____

Insurance Address _____

ID or Certificate No.: _____ Group No.: _____

Secondary Insurance Company _____

lnsured's Name _____ lnsured's S.S.# _____

Insurance Address _____

ID or Certificate No.: _____ Group No.: _____

RELEASE OF INFORMATION

I AUTHORIZE any physician to release all information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to the Insurance Company and/or its Representative. Assignment of benefits is allowed as designated by this office.

I AUTHORIZE verification of employment, residence, any and/or all facts included within this document to be released to North Bay Family Medical Clinic, P.A. I AUTHORIZE North Bay Family Medical Clinic to obtain any credit reports as necessary, for collection purposes only. A photocopy or facsimile reproduction of this authorization may be used in place of this original document.

All professional services rendered are the responsibility of the patient regardless of insurance coverage. If an account is placed for collections, there will be a 40% service fee added. It is the Patient's responsibility to pay any and all outstanding amounts due plus service fees, and fees of an attorney, court costs, collection agency and credit bureau fees.

I agree that this authorization shall be valid until rescinded in writing or replaced by one at a later date.

Date _____ Signed _____

(Patient, Parent, or Legal Guardian Signature)

(Relationship to Patient) _____

NORTH BAY FAMILY MEDICAL CLINIC

HIPPA AND AUTHORIZATION FOR PAYMENT

Thank you for choosing North Bay Family Medical Clinic for your medical care. The following are some of our office policies in regard to insurance and payment.

- It is your responsibility to know if the doctor you are seeing is listed on your current insurance plan, otherwise YOU will be responsible for all charges.
- If you have a copayment for doctor visits, it must be paid at check-in before seeing the doctor.
- Full payment is due at the time of service if insurance does not apply.
- If your doctor refers you to a specialist, your insurance company may require preapproval. You must check with your insurance company to see if this applies.

I hereby authorize payment to NORTH BAY FAMILY MEDICAL CLINIC, P.A., and authorize release of all medical information to secure payment. This form constitutes "My Signature on File" for the purpose of filing a claim with my msurance.

I hereby give my consent for North Bay Family Medical Clinic to use and disclose protected health information about me to carry out treatment, payment, and health care operations (TPO).

North Bay Family Medical Clinic may call my home and leave a message on my answering machine or voice mail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations. I acknowledge that I have received the "Notice of Privacy Practices" which describes such uses and disclosure more completely.

By signing this form, I am consenting to allow North Bay Family Medical Clinic to use and disclose my private healthcare information (PHI) to carry out treatment, payment, and healthcare operations (TPO). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, North Bay Family Medical may decline to provide treatment to me.

PRINT PATIENT NAME _____

Date _____ Signed _____

NORTH BAY FAMILY MEDICAL CLINIC

RELEASE OF INFORMATION TO THIRD PARTY

THIS SECTION MUST BE SIGNED REGARDLESS IF YOU LIST ANY THIRD PARTY

I authorize North Bay Family Medical Clinic to address any and/or all inquiries in regards to my appointments, messages, account activity, and/or any medical inquiries or conditions with the following persons:

Print Name of Person _____ Relationship to Patient _____

Print Name of Person _____ Relationship to Patient _____

PATIENT NAME _____

Date _____ Signed _____

AUTHORIZATION OF RELEASE FOR MEDICAL CARE

I authorize the persons below to accompany _____ (minor child) for appointments and give my permission for medical care to be administered.

Print Name of Person _____ Relationship to Patient _____

Print Name of Person _____ Relationship to Patient _____

PARENT, or LEGAL GUARDIAN SIGNATURE _____

Date _____

NORTH BAY FAMILY MEDICAL CLINIC

NAME _____ DATE ___ / ___ / ___ BIRTHDATE ___ / ___ / ___

REFERRED BY _____ AGE _____

REASON FOR VISIT ☐ ROUTINE PHYSICAL ☐ PROBLEM

DESCRIBE PROBLEM _____

_____

CHECK IF YOU HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST:

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Anemia			Emphysema		
Anxiety			Gastric Intestinal Bleed		
Arthritis / Joint pain			Heart Attack		
Asthma			Heart Murmur		
Back Problems			Hepatitis/Jaundice		
Blood Infusions			High Cholesterol		
Bowel Trouble			Hypertension		
Brain Aneurysm*			Hyperthyroid		
Cancer			Hypothyroid		
Breast			Kidney Stones		
Colon			Lupus		
Lung			Mood Disorder		
Prostate			M.S.		
Chronic Obstructive Pulmonary Disease			Osteoporosis		
Chronic Recurrent Cough			Pneumonia		
Colon Polyps			Prosthetic		
Diabetes Mellitus			Rheumatoid Arthritis		
Type I Age of Onset _____			Sinus Problems		
Type II Age of Onset _____			Sexually Transmitted Disease		
Dialysis (Kidney Failure)			Stroke		
Diverticulitis			Ulcers		

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

	DATE		DATE
Abnormal PAP Smear		Tetanus	
Bone Density		Mammogram	
Colonoscopy / Sigmoidoscopy		Last PAP Smear	
Flu Shot		TB Skin Test	
Pneumonia		Hemocult	
OTHER:		OTHER:	

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON:		SURGERY / REASON:	

NORTH BAY FAMILY MEDICAL CLINIC

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

DRUG NAME	DOSAGE	PHYSICIAN	DRUG NAME	DOSAGE	PHYSICIAN
ALLERGIES TO MEDICATIONS / SUBSTANCES (LATEX GLOVES, ETC.?)			LIST: _____ _____		

IMMEDIATE FAMILY MEMBERS IN SAME HOUSEHOLD

NAME	AGE	RELATIONSHIP TO PATIENT

CIRCLE AND CHECK IF YOUR BLOOD RELATIVES HAVE HAD:

MAJOR ILLNESSES	YES	NO	WHAT BLOOD RELATIVE?
Asthma			
Brain Aneurysm			
Cancer			
Breast			
Colon			
Lung			
Prostate			
Colon Polyps			
Diabetes Mellitus			
Type I Age of Onset _____			
Type II Age of Onset _____			
Dialysis (Kidney Failure)			
Heart Attack			
High Cholesterol			
Hypertension			
Mood Disorder			
Stroke			
Other _____			

YOUR OB HISTORY

	NUMBER		NUMBER
Total # of Pregnancies		# of Births	
# of Vaginal Deliveries		Abortions Induced	
# of C-Sections		Living Children	
Miscarriages			

NORTH BAY FAMILY MEDICAL CLINIC

YOUR GYN HISTORY

	YES	NO		YES	NO
Do you use birth control?			Nuvaring		
Condoms			Birth Control Patch		
Depo Provera			Natural Family Plan / Rhythm		
Diaphragm			Tubal Ligation		
IUD-Kind Date Inserted _____			Vasectomy		
Birth Control Pill Name _____			Withdrawal Other		
Contraceptive Foam / Jelly					

What age did you have your first period: _____ How long does your period last? _____days
Flow: Light _____ Medium _____ Heavy _____
Date of last period _____
Have you gone through Menopause: Yes _____ No _____ At what age? _____
Are you on Hormone Replacement Therapy hormones? Yes _____ No _____

SOCIAL HISTORY

Marital Status: Divorced _____ Married _____ Single _____ Widowed _____

Substance Use:

___ Alcohol
___ Caffeine
___ Cigarette Smoking
___ Cocaine
___ No Drug use
___ Substance abuse
___ Former smoker
___ Never smoked
___ Never used alcohol
___ IV Drugs
___ Marijuana
___ Narcotics
___ Non-smoker
___ Other substance abuse
___ Smokeless tobacco
___ Smoker

Exercise:

___ Active but no formal exercise
___ Competitive Athlete
___ Exercises regularly
___ Heavy amount of exercise
___ Minimal amount of exercise
___ Moderate amount of exercise
___ Sedentary

OCCUPATION

Please list your occupation and number of years of service: _____

Education:

___ College Attendee
___ College graduate, 2 yr
___ College graduate, 4 yr
___ Did not attend school
___ GED
___ Graduate studies
___ High school attendee
___ High school graduate
___ Post graduate studies
___ Professional degree
___ Professional studies

Risk Violence:

___ Denies emotional abuse by spouse/ parent
___ Denies physical abuse by spouse/ parent
___ History of emotional abuse
___ History of physical abuse
___ History of sexual abuse
___ Report of abuse to local authority

Travel History:

___ Does not use seatbelts
___ Risk for AIDS/HIV
___ Risk for travel-related illness

NORTH BAY FAMILY MEDICAL CLINIC

NAME _____ DATE ___ / ___ / ___ BIRTHDATE ___ / ___ / ___

REVIEW OF SYSTEMS: PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU NOW.

CONSTITUTIONAL
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Hot Flashes

EYES
- ☐ Double vision
- ☐ Vision changes

RENT
- ☐ Headaches
- ☐ Dizziness
- ☐ Sore Throat
- ☐ Sinus Pain
- ☐ Nose Bleeding
- ☐ Thyroid Mass
- ☐ Neck Pain

BREAST
- ☐ Lumps
- ☐ Tenderness
- ☐ Swelling
- ☐ Discharge
- ☐ Pain in Breast
- ☐ Abn Changes in Breast

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beats
- ☐ Rapid Heart Rate
- ☐ Fainting
- ☐ Swelling of legs
- ☐ Varicose veins

RESPIRATORY
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Spitting up blood

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Bloody/ Black Stool
- ☐ Hemorrhoids
- ☐ Jaundice

GENITOURNARY
- ☐ Urgency of urination
- ☐ Frequency of urination
- ☐ Pain with urination
- ☐ Nighttime urination
- ☐ Losing urine
- ☐ Blood in urine
- ☐ Decreased sex drive
- ☐ Painful intercourse
- ☐ Possible Pregnancy
- ☐ Genital Sores

SKIN
- ☐ Rashes
- ☐ Itching
- ☐ Skin Dryness
- ☐ Skin Lesions
- ☐ Changes to Lesions or Moles
- ☐ Acne

NEUROLOGICAL
- ☐ Muscular Weakness
- ☐ Numbness or Tingling
- ☐ Difficulty Concentrating
- ☐ Memory Difficulties
- ☐ Speech Difficulties
- ☐ Seizures
- ☐ Loss of Balance

MUSCULOSKELETAL
- ☐ Joint Pain or Swelling
- ☐ Muscle Pain
- ☐ Back Pain

ENDOCRINE
- ☐ Loss of Hair
- ☐ Difficulty Tolerating Cold
- ☐ Difficulty Tolerating Heat

PSYCHIATRIC
- ☐ Anxiety Depression
- ☐ Impulsive Behavior
- ☐ Suicidal Thoughts
- ☐ Excessive Anger
- ☐ Mood Swings
- ☐ Emotional Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse

HEMATOLOGIC / LYMPHATIC
- ☐ Bruises, frequent or easily
- ☐ Cuts do not stop bleeding
- ☐ Enlarged lymph nodes

ALLERGIC / IMMUNOLOGIC
- ☐ Frequent illness
- ☐ Seasonal Allergies

☐ **OTHER / NOTES**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____