

# Mt. Juliet Family Care & Walk-In Clinic, LLC - Registration Form

## Patient Information:

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: M S D W SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email address: \_\_\_\_\_ (review email communication agreement on back)

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

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## Employer Information:

Patients Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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## Parent or Financially Responsible Party (if different than patient)

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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## Primary Insurance

Insurance Name: \_\_\_\_\_ Cardholders Relationship to Patient: \_\_\_\_\_

ID #: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

## Secondary Insurance

Insurance Name: \_\_\_\_\_ Cardholders Relationship to Patient: \_\_\_\_\_

ID #: \_\_\_\_\_ Co-Pay Amount: \_\_\_\_\_

**Please Present Insurance Cards And Picture ID At Reception Desk**

Do you have a living will, durable power of attorney, or advanced directives?	Yes	No
If No, would you like information?	Yes	No

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### **Insurance Information:**

I authorize Mt. Juliet Family Care & Walk-in Clinic, LLC (MJFC) to furnish information to insurance carriers concerning my care. I agree to pay MJFC for all services rendered to my dependants or myself. I understand that I am responsible for any amount not covered by my insurance and if I have not secured appropriate authorizations and otherwise complied with the terms of my benefit plan there may be a decrease or no coverage at all for services rendered at MJFC. For self-pay patients, I also understand that I am responsible for all services rendered to my dependants or myself.

Full payment of Co-pays and self-pay charges are due the time of service.

I understand that the responsible party will be assessed a fee as determined by Check Redi for all returned checks.

Any balance is ultimately my responsibly and in the event my balance is transferred to a collection agency or attempts are made to collect a delinquent balance using an outside source, I will be responsible for collection costs, attorney fees, and /or court cost up to and beyond the existing balance incurred.

I understand that if Workers' Compensation or another carrier is liable for my bills, my personal insurance is not responsible for payment. I understand that all insurance information must be given to MJFC before or at the time of service.

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### **Consent to Treat & Medical Records Release Authorization:**

I authorize MJFC providers to provide treatment that they may deem advisable for my dependants and myself. I understand that these services are voluntary and I have the right to refuse these services. In the event of a life-threatening emergency, I consent for the provider to administer emergency treatment.

I authorize MJFC to obtain any previous medical records, for my dependants or myself, including lab and imaging results, if my providers feel it is necessary for the care of my dependants or myself.

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### **e-Communication Agreement**

This policy is intended for patients that have a password-protected email and is checked at least 2-3 times per week. MJFC will only communicate electronically with the approved email address you have provided. When requesting information please include your full name and birth date in the message to establish reasonableness that the sender requesting information is who the sender claims to be. The subject of the email should include the providers name and the purpose of the email.

Do not use email to request very sensitive information. MJFC cannot and does not guarantee the privacy or security of any message sent over the internet. There is the potential that email sent over the internet can be intercepted and read by others.

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**I have read the above items regarding insurance and financial responsibility, consent and medical records and e-communication and agree to the terms and conditions related to each item.**

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**Patient or Responsible Party Signature**

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**Date**

**Patient Medical, Surgical, Social & Family History**

Date: \_\_\_\_\_ Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Medical History****Medication Allergies:** \_\_\_\_\_**List all Current Medications** (prescriptions, OTC, or herbal remedies) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Pharmacy:** (Mt. Juliet Pharmacies -  Eckerd  Kroger (N. Mt. Juliet Rd or Providence?)  Pharmacare  Rite Aid  
 Target  Walgreens (N. Mt. Juliet Rd. or Providence?) **Other w/ phone number:** \_\_\_\_\_**Patient Health History**  No History of Illness

- |   |   |
|---|---|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Hearing Loss             |
| <input type="checkbox"/> Allergies (Seasonal)     | <input type="checkbox"/> Heart Attack             |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Heart Burn (acid reflux) |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> High Blood Pressure      |
| <input type="checkbox"/> Bipolar                  | <input type="checkbox"/> High Cholesterol         |
| <input type="checkbox"/> Cancer (location? _____) | <input type="checkbox"/> Hypothyroid              |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Interstitial Cystitis    |
| <input type="checkbox"/> COPD / Emphysema         | <input type="checkbox"/> Kidney Stones            |
| <input type="checkbox"/> Crohn's                  | <input type="checkbox"/> Mental Retardation       |
| <input type="checkbox"/> Depression / Anxiety     | <input type="checkbox"/> Migraine Headaches       |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Diverticulitis           | <input type="checkbox"/> Stomach Ulcers           |
| <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Gout                     |   |

**Health Maintenance:**

Date of Last Complete Physical: \_\_\_\_\_

Date of Last Bone Density: \_\_\_\_\_

Date of Last Colonoscopy: \_\_\_\_\_

Date of Last Tetanus Immunization: \_\_\_\_\_

**Women Only:**

Date of last Mammogram: \_\_\_\_\_

Date of last Pap: \_\_\_\_\_

 Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Hospitalizations:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Patient Surgical History** (List below all past surgeries)  No History of Surgeries

- |   |  |
|---|--|
| <input type="checkbox"/> Appendix Removed                 | <input type="checkbox"/> Mastectomy                                |
| <input type="checkbox"/> Artificial Joints _____          | <input type="checkbox"/> Pace Maker                                |
| <input type="checkbox"/> C-Section                        | <input type="checkbox"/> Pins or Plates inserted (location: _____) |
| <input type="checkbox"/> D & C                            | <input type="checkbox"/> Spleen Removed                            |
| <input type="checkbox"/> Ear Tubes                        | <input type="checkbox"/> Thyroid Removed                           |
| <input type="checkbox"/> Gall Bladder Removed             | <input type="checkbox"/> Tonsils Removed                           |
| <input type="checkbox"/> Hernia ( Left / Right )          | <input type="checkbox"/> Tubal Ligation                            |
| <input type="checkbox"/> Hysterectomy ( Partial / Total ) |  |

 Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Family Health History**

**Father**

List any health problems: \_\_\_\_\_

No Known Health Problems

Has Died – Age and Cause of Death: \_\_\_\_\_

**Mother**

List any health problems: \_\_\_\_\_

No Known Health Problems

Has Died – Age and Cause of Death: \_\_\_\_\_

**Brothers**

How many \_\_\_\_\_

No Known Health Problems. List any health problems: \_\_\_\_\_

**Sisters**

How many \_\_\_\_\_

No Known Health Problems. List any health problems: \_\_\_\_\_

**Social History**

• Marital Status: M S D W

• Patients occupation \_\_\_\_\_

• Alcohol use? Yes No Average amount - \_\_\_\_\_ / Day Week Month Year

• Smoke or Tobacco use? Yes No How many Packs per Day \_\_\_\_\_ Smokeless Tobacco? Yes No

• Caffeine ( soda, tea, coffee )? Yes No Average amount - \_\_\_\_\_ / Day Week Month Year

Please describe any other information that you feel your health care provider should know: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person documenting above medical history: (if other than patient): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Mt. Juliet Family Care & Walk-In Clinic, LLC – HIPAA/Permission From**

The Health Insurance Portability and Accountability Act (HIPAA) requires MJFC to notify patients regarding how their Protected Health Information is handled. Our HIPPA policy is posted in the Lobby. You have the right to review the HIPPA policy and you may request a copy of the policy

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With your permission, we may disclose your Protected Health Information to a family member, close friend or any other person that you identify.

I, \_\_\_\_\_, authorize MJFC to release any personal information relating to my health care

To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____
To: _____	Relationship to patient: _____

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I have reviewed the HIPPA Notice of Privacy Practices for MJFC. I hereby acknowledge that I am familiar with and understand the terms of this policy.

Print Patient Name: \_\_\_\_\_

Patients / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_