

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: _____

Employer Information:

Patients Employer: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent or Financially Responsible Party (if under 18) **Must have Photo ID available**

First: _____ Middle: _____ Last: _____ Male Female

Date of Birth: ____/____/____ SS#: ____/____/____ Employer: _____

Address: ____ Same As Above _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ (W) _____

Relationship to Patient: _____

Primary Insurance **MUST PRESENT INSURANCE CARD**

Insurance Name: _____ Co-Pay Amount: _____

Cardholders Relationship to Patient _____ Employer: _____

First: _____ Middle: _____ Last: _____ Male Female

Date of Birth: ____/____/____ SS#: ____/____/____

Secondary Insurance **MUST PRESENT INSURANCE CARD**

Insurance Name: _____ Co-Pay Amount: _____

Cardholders Relationship to Patient _____ Employer: _____

First: _____ Middle: _____ Last: _____ Male Female

Date of Birth: ____/____/____ SS#: ____/____/____

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

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 responsibility. 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.

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.

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. MJFC can be contacted via email through our website at www.mjfamilycare.com. 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 provider's name and the purpose of the email.

This office will use the provided email address to communicate directly with you. It will not be released to any third party other than for use of treatment, payment and healthcare operations. MJFC cannot and does not guarantee the privacy or security of any message sent over the internet. There is the potential that an email sent over the internet can be intercepted and read by others.

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.

Patient or Responsible Party Signature

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 - Kroger (N. Mt. Juliet Rd or Providence?) Publix (Lebanon Rd or Providence?) Pharmicare
 Rite Aid Target Walgreens (N. Mt. Juliet Rd. or Providence?) Walmart **Other** _____**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
- Occupation of Patient _____
- 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

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: _____

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: _____