# WALLACE FAMILY PRACTICE, P.A.
## PATIENT REGISTRATION

DATE: ___________

**PATIENT INFORMATION:**
**DR. LIC#:** ________________________ **SOC. SEC. #:**____________________ **REFERRED BY:**____________

PATIENT NAME:_______________________________________________ M F DATE OF BIRTH________
(LAST) (FIRST) (MIDDLE) (CIRCLE ONE)

ADDRESS: ________________________________________________ APT. #:___________

CITY: _____________________________________ STATE: ________ ZIP: __________

HOME PHONE: (______) ______________________ CELL PHONE: (______) ____________________

E-MAIL ADDRESS: ________________________________________________________________

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**EMPLOYER:** _________________________________ OCCUPATION: __________________

ADDRESS: ___________________________________ BUS. PHONE: (_____) ____________

CITY: __________________ STATE: __________ ZIP: ____________

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**PARENT/GUARDIAN INFORMATION:**

PARENT/GUARDIAN NAME: __________________RELATIONSHIP TO PATIENT: _________________

ADDRESS: ____________________________________________APT. #:___________

CITY: __________________ STATE: ___________ ZIP: ___________

HOME PHONE: (_____) ______________________ WORK PHONE: (_____) ____________________

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**EMERGENCY CONTACT:** _____________________ RELATIONSHIP TO PATIENT:______________

ADDRESS:__________________________________________ APT.#: _______________________

CITY:______________________ STATE: _____________ ZIP: ______________

HOME PHONE: (_____) __________________________ WORK PHONE: (____) ____________________

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**INSURANCE INFORMATION:**

INSURANCE NAME: ________________________________________________

POLICY ID#: ______________________________________________________

POLICY HOLDER'S NAME: ___________________________________________

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _______________________

POLICY HOLDER'S DATE OF BIRTH: _________________________

# WALLACE FAMILY PRACTICE, P.A.
## PATIENT REGISTRATION

# HEALTH HISTORY QUESTIONNAIRE

TODAY'S DATE: ____________

LAST NAME: ____________________________FIRST NAME: _______________________MI______

BIRTHPLACE___________________________ EDUCATION LEVEL________________

SINGLE_______MARRIED_______SEPERATED_______DIVORCED_______WIDOWED_______

WHO LIVES AT HOME WITH YOU? ____________________________________________________

**MEDICAL HISTORY** PLEASE CHECK ANY CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST

| | | | |
|---|---|---|---|
| □ HEART DISEASE | □ CANCER | □ RHEUMATIC FEVER | □ ANEMIA |
| □ STROKE | □ BREAST LUMP | □ TUBERCULOSIS | □ BLEEDING DISORDER |
| □ DIABETES | □ PROSTATE PROBLEM | □ HEPATITIS | □ THYROID PROBLEM |
| □ HIGH BLOOD PRESSURE | □ CATARACTS | □ HERPES | □ KIDNEY DISEASE |
| □ HIGH CHOLESTEROL | □ GLAUCOMA | □ VENEREAL DISEASE | □ LIVER DISEASE |
| □ ASTHMA | □ MIGRAINE HEADACHES | □ HIV/AIDS | □ ANXIETY/DEPRESSION |
| □ EMPHYSEMA | □ EPILEPSY | □ ARTHRITIS | □ ALCOHOL/DRUG ABUSE |

OTHER (LIST BELOW):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**HOSPITALIZATIONS** LIST ALL HOSPITALIZATIONS FOR ILLNESS OR SURGERY BEGINNING WITH THE MOST RECENT.

| **DATE** | **REASON** | **HOSPITAL** | **PHYSICIAN** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICATIONS, VITAMINS, SUPPLEMENTS**

OUR STAFF WILL ENTER YOUR PRESCRIPTION MEDICATIONS INTO OUR ELECTRONIC MEDICAL RECORD SYSTEM. PLEASE HAVE THAT INFORMATION READY. CIRCLE THE FOLLOWING NON-PRESCRIPTION MEDICATIONS THAT YOU USE.

| | | | |
|---|---|---|---|
| LAXATIVES | ANTACIDS | ASPIRIN | IBUPROFEN OR NAPROXEN |
| DECONGESTANTS | ALLERGY PILLS | NASAL SPRAYS | NATURAL HORMONES |
| VITAMINS | HERBS (PLEASE LIST) | SUPPLEMENTS | OTHER (LIST BELOW): |

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**ALLERGIES** IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING PLEASE DESCRIBE THE REACTION YOU HAD.

PENICILLIN________________ SULFA_________________ OTHER_______________________________________

**LIFESTYLES AFFECTING HEALTH** PLEASE ANSWER THESE QUESTIONS.
WEIGHT: NOW______ 1YEAR AGO______ DESIRED______
HABITS: USE SEAT BELTS 80-100%______ 50-80%______ LESS THAN 50% _____
TOBACCO: NEVER______ AGE STARTED______ AGE STOPPED______
CIGARETTES: #PACKS A DAY ______ CIGARS______ PIPE______ SNUFF______ CHEWING TOBACCO______
ALCOHOL: NEVER______#0-6 DRINKS/WEEK______ 7-14 DRINKS/WEEK______ OVER 14/WEEK ______
CAFFEINE: DRINKS PER DAY______ SPECIAL DIET? TYPE___________________________________________
EXERCISE: TYPE: ______________________ FREQUENCY, DISTANCE, OR AMOUNT: _________________________
WOMEN: DO YOU DO REGULAR BREAST SELF-EXAMS? □ YES □ NO
MEN: DO YOU DO REGULAR TESTICULAR SELF-EXAMS? □ YES □ NO

Patient Name: ______________________________________________________

## FAMILY HISTORY

| FAMILY HISTORY | If living | | If Deceased | | Family Disease | √ | Relationship to patient |
|---|---|---|---|---|---|---|---|
| | Age | Health | Age | Cause | Allergies | | |
| Father | | | | | Asthma | | |
| | | | | | Arthritis | | |
| Mother | | | | | Glaucoma | | |
| 1. Brother/Sister (circle one) | | | | | Cancer – what kind? | | |
| | | | | | Tuberculosis | | |
| 2. Brother/Sister (circle one) | | | | | Diabetes | | |
| | | | | | Heart trouble | | |
| 3. Brother/Sister (circle one) | | | | | High Blood Pressure | | |
| | | | | | Stroke | | |
| 4. Brother/Sister (circle one) | | | | | High Cholesterol | | |
| | | | | | Stomach ulcers | | |
| Spouse | | | | | Epilepsy/Seizure | | |
| | | | | | Substance abuse | | |
| 1. Son/Daughter (circle one) | | | | | Anxiety | | |
| | | | | | Depression | | |
| 2. Son/Daughter (circle one) | | | | | Suicide | | |
| | | | | | Kidney trouble | | |
| 3. Son/Daughter (circle one) | | | | | Birth defects | | |
| | | | | | Sickle cell anemia | | |
| 4. Son/Daughter (circle one) | | | | | Mental retardation | | |
| | | | | | | | |

**PREVENTIVE SERVICES** List the date you last had these preventive medical services or tests.

Physical examination: _________________ Physician: ________________________

**Heart Disease Prevention**:

High cholesterol: Lipid profile __________

**Cancer Screening**:

Breast cancer: Mammogram ______________

Cervical cancer: PAP smear ________________

Colon cancer: Colonoscopy_________ OR stool test_________ plus flexible sigmoidoscopy ______

**Infectious Disease Prevention: (List year of most recent immunization)**

MMR __________ Tetanus __________ Hepatitis B _____________

Flu ___________ Pneumonia _____________ Hepatitis A _____________

**Osteoporosis Screening:**

DEXA Scan (bone density test) _______________

## MENSTRUAL HISTORY

Age at onset ________

Cycle (from start to start) __________ days (ie: 28 days)

Date of last period ___________

If post-menopausal, age at last period _____________

Usual duration of flow ___________ days

Flow is: Heavy ___ Medium ___ Light ____

Pain or cramp? ________

Periods irregular? ____________

Taking birth control pills? ____________

Have had vaginal infections or frequent discharge? ________

Have an IUD? ______________

Have had abnormal PAP? ______________

Total Pregnancies _____________

Number of children born alive? ____________

**PATIENT NAME:** ______________________________________________________

**REVIEW OF SYSTEMS:** **Please circle any symptoms you have had in the past 6 months. Not circling a symptom means you have not experienced it.**

**General**
Fevers
Chills
Sweats
Loss of appetite
Fatigue
Weakness
Malaise
Weight loss

**Eyes**
Blurring
Double vision
Irritation
Discharge
Vision loss
Eye pain
Eye pain in light

**Ear/Nose/Throat**
Earache
Ear discharge
Decreased hearing
Nasal congestion
Nose bleeds
Sore throat
Hoarseness
Difficulty swallowing

**Cardiovascular**
Chest Pain
Fainting
Shortness of breath walking
Shortness of breath laying flat
Shortness of breath at night
Leg swelling

**Respiratory**
Cough
Shortness of breath
Excessive sputum
Coughing up blood
Wheezing
Pleurisy

**Gastrointestinal**
Nausea
Vomiting
Diarrhea
Constipation
Change in bowel habits
Abdominal pain
Black stool
Bloody stool
Jaundice
Gas/Bloating
Indigestion/heartburn
Pain with swallowing

**Female Genitourinary**
Vaginal discharge
Incontinence
Pain with urination
Blood in urine
Get up at night to urinate
Urinary frequency
Missed period
Heavy period
Abnormal vaginal bleeding
Pelvic pain
Genital sores
Painful intercourse
Decreased sexual drive

**Male Genitourinary**
Pain with urination
Blood in urine
Discharge
Urinary frequency
Urinary hesitancy
Incontinence
Get up at night to urinate
Decreased libido
Erectile dysfunction
Genital sores

**Musculoskeletal**
Back pain
Joint pain
Joint swelling
Muscle cramps
Muscle weakness
Stiffness
Arthritis
Sciatica
Restless legs
Leg pain at night
Leg pain with exercise

**Skin**
Rash
Itching
Dryness
Suspicious lesions

**Neurological**
Paralysis
Numbness
Seizures
Tremors
Vertigo
Loss of vision
Frequent falls
Frequent headaches
Difficulty walking
Weakness
Fainting
Headache

**Mental**
Depression
Anxiety
Memory loss
Suicidal thoughts
Hallucinations
Paranoia
Phobia
Confusion

**Endocrine**
Cold intolerance
Heat intolerance
Increased thirst
Eating more
Urinating more
Weight change

**Heme/Lymphatic**
Abnormal bruising
Abnormal bleeding
Enlarged lymph nodes

**Allergic/Immunologic**
Hives
Allergic rash
Sneezing
Hay Fever
Recurrent infections
HIV exposure

# MEDICATION HISTORY AUTHORITY

Patient name: _______________________________________________ Date: ____________________

DOB: ________________________________

I, ______________________________________________________, give Wallace Family Practice, P.A. the authority to download my medication history from all and any pharmacies.

_______________________________________________________________________________

Patient Signature Date
(Parent/Guardian to sign if patient is a minor or unable to sign)

# WALLACE FAMILY PRACTICE, P.A.
## PATIENT REGISTRATION

## OFFICE POLICIES

The following sets forth the general billing policy, missed appointment policy, and prescription refill policy of Wallace Family Practice, P.A. Please review this information and sign where indicated.

I understand that it is my responsibility to provide the office of Wallace Family Practice, P.A., with current and accurate insurance/billing information at the time of check in and to notify the office of any changes in this information.

I understand that it is my responsibility to know my co-pay/co-insurance/deductible. I will pay at the time that services are rendered. I understand that this is a contractual agreement that I have with my health plan and that the office also has a contractual agreement with my health plan.

I understand that if I present an insufficient funds check (NSF CHECK) for payment on my account that I will be charged $35 NSF fee. I understand that in order to rectify my account, I will be required to pay cash or credit.

I understand that I will be billed for any amounts due by me and I have a financial responsibility to pay these amounts in a timely manner. I understand that I will be provided with four (4) monthly statements for any balance due after insurance payment. Any outstanding balance of more than ninety (90) days may affect my ability to make future appointments and /or receive medication refills. Any outstanding balance of more than ninety (90) days without effort to make payment may result in termination from the practice for non-payment.

I understand that there is a $20 fee (payable prior to completion) to complete any disability paperwork associated with my care.

I understand that I will keep any and all appointments for office visits and/or diagnostic procedures. If I am unable to keep my appointment, I will kindly give 24 hours notice.

I understand that if I miss two (2) consecutive appointments without notice of cancellation, I may be dismissed from the practice.

I understand that my account must be current prior to scheduling another appointment.

**I will bring all my prescription medications to every appointment.**
Medications will be reviewed for accuracy, appropriate dosing, and number of refills remaining. Refills will be given at the time of the appointment. I understand that Dr. Wallace reserves the right to deny refills if it has been more than six (6) months since my last appointment.

______________________________________________

**Signature** **Print Name** **Date**

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Wallace Family Practice's Notice of Privacy Practices.

Patient Name: ___________________________________________________

If you're not the patient, please state relationship:

- o Parent(s)
- o Legal Guardian
- o Son or Daughter
- o Facility Caretaker
- o Other __________________________

**To respect your privacy please tell us how we may contact you:**

**Home/Cell Phone**

- o You may leave a message with the following person(s) if I am not available:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

- o You may leave DETAILED INFORMATION on my answering machine/voicemail.
- o You may leave NAME AND PHONE NUMBER ONLY on my answering machine/voicemail and I will return your call.

**Work Phone**

- o You may call my workplace.
- o You may leave DETAILED INFORMATION on my answering machine.
- o You may leave NAME AND PHONE NUMBER ONLY on my answering machine and I will return your call.
- o You may NOT call my work place.

**Please list family, friends, et cetera that we may communicate with in regards to your personal information, which includes your health and billing records.**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Patient's Signature: ______________________________ Date: ____________

If not patient, state relationship to patient _____________________________________

# WALLACE FAMILY PRACTICE, P.A.
## PATIENT REGISTRATION

## SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY.**

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law we are required to make sure that you are protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice Privacy Practices that follows this summary):

▪ For medical treatment
▪ To obtain payment for our services
▪ In emergency situations
▪ For appointment and patient recall reminders
▪ In response to certain request arising out of lawsuits or other disputes
▪To run our practice more efficiently and ensure all our patients receive quality care

If you believe your privacy rights have been violated, you may file a complaint with the practice or with Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

▪ The right to inspect and copy
▪The right to amend
▪The right to an accounting of disclosures
▪ The right to request restrictions
▪ The right to a paper copy of this notice
▪ The right to request confidential communications

For more information about these rights, please see the detail Notice of Privacy Practices.