Midha Medical Clinic
REGISTRATION FORM

Today's Date____/____/___ **(PLEASE PRINT NEATLY)**

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____

IS THIS YOUR LEGAL NAME? □YES □NO IF NOT, WHAT IS YOUR LEGAL NAME_____

DATE OF BIRTH___/___/_____ AGE:_____ SEX: MALE□ FEMALE□ RACE_____

SS#____/___/_____ MARITAL STATUS: MARRIED □ SINGLE□ WIDOWED□ DIVORCED□

STREET ADDRESS:_____

CITY/STATE/ ZIP:_____

□Home Phone _____□Cell Phone _____□Work Phone _____Ext___

Email Address_____

INSURANCE INFORMATION **(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**

PRIMARY INSURANCE

INSURANCE PLAN:_____SUBSCRIBER ID:_____GRP:#_____

NAME OF POLICYHOLDER:_____

POLICYHOLDER BIRTHDATE_____RELATIONSHIP TO POLICYHOLDER:_____

POLICYHOLDER ADDRESS (if different from the above address):_____

CITY/STATE/ZIP:_____PHONE:_____

SECONDARY PLAN (if applicable)_____POLICYHOLDER:_____

SUBSCRIBER ID:_____GRP:#_____

PERSON RESPONSIBLE FOR BILL_____ □Parent □Spouse □Partner SS#_____

ADDRESS (if different)_____

IN CASE OF EMERGENCY

EMERGENCY CONTACT:_____RELATIONSHIP:_____

(someone not living at your home as we will contact your immediate family members first if possible)

HOME PHONE:_____ CELL/WORK PHONE:_____

<u>Instructions:</u> All patients must sign statement "A" below. Patients with Medicare, Medicaid or PPO insurance plans are required to sign statement "B" by law or by their insurance contract. If you have other insurance plans and want us to file your insurance claims, you must sign statement "B". If you intend to file your own insurance claim and agree to pay in full for your medical service at the time of visit, sign Statement "C".

<u>STATEMENT "A"</u>: I understand that although I have given Midha Medical Clinic my insurance information, I am responsible for all medical charges incurred with Midha Medical Clinic, should my insurance coverage terminate or not cover charges for services rendered.

_____ _____

Signature Date

<u>STATEMENT "B"</u>: AUTHORIZATION TO FILE INSURANCE AND RELEASE MEDICAL INFORMATION.

To file an insurance claim on your behalf we need your signature on file permitting us to do so. In the event that you have already paid your bill and the insurance check come to us, we will promptly mail you a refund check. If we receive a check from your insurance company and your account has a balance due, we will apply these funds to the outstanding balance. In the event these funds do not cover the entire amount due, we will bill you for the balance.

By signing below, I hereby agree to the above terms and authorize and hereby assign payment of my insurance benefits directly to Midha Medical Clinic for medical services rendered to me by Dr. Midha. Furthermore, I authorize the release of medical information necessary to process my medical insurance claims.

I hereby release Midha Medical Clinic and its' agents and employees from my liability or damages which may arise from the release of the information authorized above.

_____ _____

Signature Date

In the event that the patient is unable to give authorization for him or herself, I as his/her representative do hereby grant permission for the above.

_____ _____

Signature Date

<u>STATEMENT "C"</u>: I PREFER TO FILE MY OWN INSURANCE AND PAY FOR SERVICES RENDERED AT TIME OF VISIT.

If you intend to file you own insurance claims, you must sign below and pay for services in full at time of visit. When you applied for your health insurance, you gave your insurance company the right to request medical information from us about you. This means that if your insurance company presents a properly authorized request for release of medical information, we are required to comply regardless of whether you sign statement "A", "B" or "C".

_____ _____

Signature Date

PATIENT MEDICAL HISTORY

LIST KNOWN MEDICAL PROBLEMS: (arthritis, cancer, hypertension, cholesterol, diabetes, thyroid, etc)

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

MEDICATIONS (All medications you are currently taking, including over the counter)

Name	Dosage (Milligrams)	Times per day
1.		
2.		
3.		
4.		
5.		
6.		

MEDICATION ALLERGIES

Medication	Reaction:
1.	
2.	
3.	
4.	
5.	
6.	

PHARMACY NAME and LOCATION_____

PHARMACY NUMBER _____

By signing this consent form you are agreeing that Midha Medical Clinic can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____

Signature of Patient or Guardian Date

SURGICAL HISTORY:

DATE: **SURGERY:**

1._____

2._____

3._____

4._____

HOSPITALIZATIONS:

DATE: REASON:

1._____

2._____

3._____

4._____

FAMILY HISTORY:

INSTRUCTIONS: From the list below, please circle those conditions found among your family members.

High Blood Pressure	Heart Disease	Diabetes
Stroke	Atherosclerosis	Kidney Disease
Tuberculosis	Thyroid Disease	Osteoporosis
Colon Cancer	Skin Cancer	Stomach Cancer
Malignant Melanoma	High Cholesterol	High Triglycerides
Heart Attacks	Heart Failure	Cancer
Obesity	Depression	Suicide

Family Member	Status Alive/deceased	Age	List Medical Condition
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Brothers			
Sisters			

SOCIAL HISTORY:

Spousal Status (Please Circle): Married Partnered Single Widowed Divorced

Living Arrangement (Please Circle): Live alone Live with other(s)
Live with whom?

_____

Children: Yes/No Number of Children Ages of Children

_____

Current or past
occupation_____

Have you been exposed to any dangerous fumes, chemicals, cotton dust, or radiation sources? □Yes □No

TOBACCO

Have you used tobacco products? □Yes □No □Never

How many years (or did) you use tobacco? _____

Cigarettes: Packs smoked each day: ½ 1 2 3 4 (PLEASE CIRCLE ONE)

Cigars: Number of cigars smoked each day? _____

Pipe: Number of ounces of tobacco each week_____

Smokeless tobacco: Ounces used each week_____

If you stopped using tobacco, in what year did you do so? _____

ALCOHOLIC BEVERAGES

Do you now use alcoholic beverages on a regular basis? □Yes □No □Never

Beer: Number of cans per week _____

Wine: Number of glasses per week _____

Whiskey/Liquor: Number of ounces consumed weekly _____

In your opinion, do you now or have you ever had a drinking problem □Yes □No □Never

Have you ever used recreational drugs? □Yes □No

If yes, which drugs?

_____