ALTMED MEDICAL CENTER, INC

***GAINESVILLE , MANASSAS, WOODBRIDGE, LURAY, CLINTON MARYLAND*,**

PLEASE PRINT **PATIENT REGISTRATION FORM** **PLEASE PRINT**

Patient Name: _____
Last First Middle Mr.,Mrs.,Ms.,Miss

Address:_____

City:_____ST:_____ZP:_____ Home Phone#: (_____)_____

Work Phone #: (_____)_____ Patient Cell Phone: (_____)_____ E-Mail Address: _____

Date of Birth:_____/_____/_____Patients Social Security#:_____/_____/_____ Sex: M/F Martial Status: M S W D O

INSURANCE INFORMATION

PRIMARY Insurance Carrier:_____Phone #:(____)_____

ID#:_____ Group #:_____

Name of Policy Holder:_____Sex :M / F Date of Birth:_____/_____/_____

Policy Holders Address_____Home Phone #:(____)_____

Work Phone #:(____)_____Policy Holders Employer:_____

Employers Insurance Plan:Y/N Relationship of Patient to Policy Holder: Self Husband Wife Child Other

SECONDARY Insurance Carrier:_____Phone #:(____)_____

ID#_____Group#:_____Name of Policy Holder :_____ Sex M / F Date of Birth:____/____/____

Policy Holders Employer_____Work Phone#:( )_____

Policy Holders Address:_____Home Phone#:(____)_____

Relationship to Patient: _____ Is this a Second Insurance through employer, retirement, or Individual policy ?

Is your visit today due to an WORKERS COMPENSATION CASE or AUTO ACCIDENT ? Y N Date of Injury _____

Are you employed:Y/N Full Time Part Time Retired Student: FT/PT Position: _____

Employer or School Name and Address:_____

Spouse or Emererggency Contact: Name _____ Spouse Social Security #:_____

Work #: (____)_____ Cell Phone: (____)_____Who Referred You to our Office ? _____

Any known Drug Allergies ? Y N If Yes What _____
Do you have a Latex Allergy ? Y N **PLEASE NOTE THIS IS NOT A LATEX FREE ENVIRONMENT**.
Do you have a Living Willing / Advance Medical Directive ? Y N Would you like to speak to a staff member about these items ? Y N
Primary Language Spoken: English Spanish French Russian Creole OTHER: _____
Name of your previous physician :_____ Phone #: (____) _____
Address:_____

Below is for Office Use Only

DATE	INITIALS	DATE	INITIALS	DATE	INITIALS

AUTHORIZATION TO PAY BENEFITS TO ALTMED MEDICAL CENTER, INC.
AND RELEASE MEDICAL INFORMATION

Please read and sign so we may facilitate processing of your insurance claims.

1. I hereby assign to ALTMED MEDICAL CENTER, INC all insurance benefits to which I am (or my child is) entitled, including but not limited to Medicare, Private Health Insurance, Medigap and any other form of coverage paying benefits.
2. I hereby authorize ALTMED MEDICAL CENTER, INC to release all necessary information to secure payment.
3. I understand that I am financially responsible for all charges, whether covered or paid by said insurance. Should ALTMED MEDICAL CENTER, INC participate with my insurance plan all co-payments and co-insurance payments are due at the time services are rendered. Should ALTMED MEDICAL CENTER, INC not participate with my insurance plan payment is due **in full** at the time services are rendered until I have made arrangements in advance with ALTMED MEDICAL CENTER, INC.
4. I understand and agree that, in the event that I fail to make payment for services rendered to my child or myself, ALTMED MEDICAL CENTER, INC may turn my account and all information over to an attorney or collection agency. I further understand that regardless of insurance coverage, that after default I will be responsible and agree to pay all fee's incurred in the collection of any outstanding balance. This may include but is not limited to, court cost, reasonable attorneys and/or collection agency fees, together with all additional costs and expenses of collections to the present extent of the law.
5. This office reserves the right to charge a monthly billing fee and or interest on all services.
6. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I hereby state that I have read and fully understand the above.

_____ _____
Signature Date Print Name

FILL OUT BELOW ONLY IF YOU HAVE MEDICARE: (required by Medicare)
Please update my records to reflect the following information:
Are you currently employed? Yes☐ No☐
If yes, are there more than 20 employees in your company? Yes☐ No☐
If retired, effective date of retirement Month _____ Year _____
Is your spouse currently employed? Yes☐ No☐
If yes, are there more than 20 employees in the company? Yes☐ No☐
If retired, effective date of retirement of spouse Month _____ Year _____
Are you or your spouse covered under any other insurance plan through a current employer? Yes☐ No☐
If retired, were you or your spouse covered under any other insurance plan while employed? Yes☐ No☐

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS PLEASE COMPLETE THE FOLLOWING:
Spouse's name: _____
Date of Birth: Month _____ Day_____ Year_____
Name and address of Employer Group Health Plan:_____
_____
Is the insurance through a current employer, a retiree program or Medigap Plan?_____
Plan ID Number:_____Group/Plan Number:_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature:_____Date:_____

PATIENT HISTORY QUESTIONNAIRE NEW PATIENT YEARLY PHYSICAL

Patient's Name:_____ Date: _____

What is the primary reason for your visit to see the doctor today? _____

What symptoms are you experiencing and how long have your had them? _____
_____

What treatment have you had towards these symptoms and when? _____
_____

Primary language spoken: _____

Medical and Surgical History

List hospitalizations, surgeries, and serious injuries

_____

_____

_____

Social History (check all that apply)

Marital: Single Married Separated Divorced Widowed

Alcohol: Never Rarely _____ drinks/week

Tobacco: Never Quit _____ packs/day for _____ years

Drugs: Never Have used Use Type: _____

Caffeine (coffee/soft drinks) amount per day: _____

Prolonged exposure to: Fumes Dust Solvents Noise

Do you feel safe in your home? _____

Do you feel sad or cry at time for no reason? _____

Cancer Screening History

Please provide the dates and results of the most recent testing.

Colonoscopy: _____

Mammogram: _____

Pap smear: _____

Family Medical History

Specify current health status or cause of death, age or age at death Medical Problems.

Father: Alive _____ Yes _____ No Age at death _____
Reason for death: _____

Mother: Alive _____ Yes _____ No Age at death _____
Reason for death: _____

Siblings

Age	Alive	Illness
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children

Age	Sex	Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____
_____

Have you ever had the following?

Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Heart trouble	Yes	No
Arthritis/gout	Yes	No
Convulsions	Yes	No
Bleeding tendency	Yes	No
Acute infection	Yes	No
Hereditary disease	Yes	No
Gynecologic infections	Yes	No

Do you presently have any problems in the following areas? If "YES" give an explanation.

Eyes:	Yes	No	_____
Ears, Nose, Mouth,	Yes	No	_____
Cardiovascular (heart, vessels	Yes	No	_____
Respiratory (lungs/breathing)	Yes	No	_____
Gastrointestinal (stomach/intesti	Yes	No	_____
Genitourinary (genitals, kidney,)	Yes	No	_____
Musculoskeletal (muscles/joints)	Yes	No	_____
Integument (skin, breasts)	Yes	No	_____
Neurological	Yes	No	_____
Psychiatric	Yes	No	_____
Endocrine (hormones/glands)	Yes	No	_____
Hematological/Immune (blood)	Yes	No	_____
Seasonal allergies (hay fever,	Yes	No	_____

List your current medications and dosages

	NAME	DOSAGE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____

WOMAN ONLY

Age menstrual period began _____ Is it **Regular** or **Irregular**
Date of last period _____ Do you have Spotting in between **Yes** **No**
Length of period _____ days Flow is **Heavy** **Medium** **Light**
# of pregnancies _____ Deliveries ____ Aborted ____ C section _____
Have you had a hysterectomy? **Yes** **No** Do you take hormones? _____
What contraceptive method to you use? _____
Onset of menopause (change of life)

Patient's signature: _____
Physician Signature: _____