

New Patient Registration

Please Print
Today's Date

PATIENT INFORMATION

Full Legal Name (Last)		(First)	(Middle)	Gender	Date of Birth
Address (Number and Street)				Name normally used (Nickname)	
City	State	Zip	Social Security No.	Driver's License #	
Home Phone	Cell Phone	Work Phone		Email Address	
Employer Name	Occupation/Job Title		Marital Status	Spouse's Name	
How Did You Hear About Us?				Spouse's Contact Phone #	

EMERGENCY INFORMATION

Person to Notify in Case of Emergency, if not spouse			Relationship
Address (Number)	(Street)	City	State
			Zip
			Phone

INSURANCE INFORMATION

Primary Insurance Company Name		Secondary Insurance Company Name	
ID number	Group Number	ID Number	Group Number
Policyholder Name, (if not patient)	Policyholder Date of Birth (if not patient)	Policyholder Name, (if not patient)	Policyholder Date of Birth (if not patient)

INFORMATION FOR THE PATIENT

Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered. Patients with contract health plans should present their insurance ID after completing this form. Some contract health plans require a copayment at time of service. If you have any questions we will be happy to assist you.

New Patient Registration and Medical Health History Questionnaire

NAME: _____ AGE: _____ DATE: _____

REASON FOR APPOINTMENT TODAY: _____

SPECIALIST PHYSICIANS you have seen in the past: _____

CHRONIC MEDICAL PROBLEMS: _____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

ALLERGIES (describe reaction): _____ SENSITIVITIES: _____

List SURGERIES you have had (include year, surgeon, hospital): _____

Describe HOSPITALIZATIONS or ILLNESSES not included above (include year, hospital): _____

Have you had (circle):	migraines	ulcer	hearing loss	gallstones
bleeding problem	blood clots	head injury	drug addiction	other: _____
tuberculosis	STDs	seizures	memory trouble	_____
psoriasis	heart murmur	rheumatic fever	shingles	_____
alcoholism	depression	mental illness	gout	

WOMEN

Age at first period _____ Date of last normal period _____ No. of pregnancies _____

No. of live births _____ No. of miscarriages or abortions _____ Birth control method _____

Date of last Pap _____ Done where _____ Normal? _____

Date of last mammogram _____ Done where _____ Normal? _____

New Patient Registration and Medical Health History Questionnaire

ALL

Who in your *family* has/had (circle if cause of death and write age of death)

heart disease _____	genetic disorder _____
diabetes _____	cancer _____
thyroid disease _____	alcoholism _____
mental illness _____	osteoporosis _____
Alzheimer's _____	asthma _____
high blood pressure _____	anything else unusual _____

When was your last:

tetanus shot _____	flu shot _____	EKG _____
TB test _____	HIV test _____	colonoscopy _____
bone density test _____	pneumonia shot _____	blood test _____

Marital status: _____ Spouse's name _____

Names and ages of your children: _____

Does anyone else live in your household? _____

Where do you work? _____

Occupation _____

Do you EXERCISE? _____ How much? _____ hrs/wk

Do you SMOKE? _____ How much? _____ packs/day Number of years _____

Used to smoke? _____ When did you QUIT? _____

Do you DRINK alcohol? _____ How much? _____ drinks/week

If you used to drink, year you QUIT _____ Previous or current problem with alcohol? _____ AA? _____

How much do you weigh? _____ How much would you like to weigh? _____ Heaviest weight _____

Please sign and date: _____

Form 08003: Acknowledgement of Receipt of Privacy Notice

Patient Name (printed): _____

Date of Birth: _____

I hereby acknowledge that I have received a copy of Wellspring Family Medicine's Financial Policy and Fee Schedule and HIPPA Notice of Privacy Practices, all my questions have been answered, and I agree to the terms therein.

Patient Signature: _____

Date: _____

For appointment confirmation and test results, we can email you very quickly. We are even able to include your actual test results with a personalized message from Dr. Reis explaining them.

Please note: although we guard your medical information carefully in the office and in our system, we cannot completely guarantee the security of information sent over the web in email form. By selecting email notification, you accept the security risks of email communication.

I would prefer to be contacted: **(PLEASE SELECT ONE)**

by email _____ (email address)

by phone: _____ home/work/cell **(PLEASE CIRCLE ONE)**

Our policy is to contact you with **all** results of tests we order, whether they are normal or not. If they are normal and you have selected phone notification, do we have your permission to leave a message? _____ (yes or no)

Do we have permission to discuss your care with any other family members or friends?

Yes: _____ (name) who is my _____.

No.

Insurance Agreement

In order to be paid fairly for services rendered, insurance companies require a 3 step process:

1. Patient is seen and at time of service pays a copay and/or coinsurance amount
2. Claim for remainder of physician's fee is submitted to insurance company
3. Statement is sent to physician with payment

If the process works perfectly, the physician's office knows exactly how much to collect at time of service and then the remaining balance is promptly paid to physician after insurance company receives bill. 😊

Unfortunately, the process often is slow and filled with seemingly unexplainable delays and denials. As a small business, we simply cannot survive without getting paid fairly and quickly for amounts owed. As a result, in order to participate in the insurance billing process we have developed some guidelines:

- According to our contract with the insurance company and the terms of your policy, we are **REQUIRED** to collect your copay and/or coinsurance amount at the time of service.
- If you have not met your deductible, you may be responsible for paying the full allowed charges at the time of service.
- For the remaining portion, we will submit a claim to your insurance company. If the remaining balance is denied for any reason, **YOU** are responsible for paying it promptly. This may include the services being determined to be not a covered service, not medically necessary, you not being a covered individual, or other reasons.
- **You may choose from one of two options for payment of any remaining balance:**
 - 1: We can store your credit/debit card information in our secure system and then charge the card when we receive the statement (usually 10-45 days).
 - 2: We can send you a bill if you agree to pay it within 10 days. There will be a fee charged for late payments.

Please know that the contracts we signed with the insurance companies are very complex, as is your policy. There may very well be situations when your insurance company denies a claim for various reasons. If we believe they are incorrect, we will try to correct the claim. However, if they deny a claim for valid reasons, you are responsible for the balance owed.

Additional Fees for Non-covered Services:

You may also be responsible for some fees that are not a covered benefit by your plan, such as filling out medical paperwork without an appointment, phone call or email consultations, missed appointment fees, returned check fees, or other fees that are generally from \$10 - \$40.

**I have read the Insurance Agreement and have had my questions answered.
I understand and agree.**

Signature: _____

Date: _____

Please choose ONE:

- I authorize Wellspring Family Medicine, LLC to charge my credit card for any balance due after my claim is processed by my insurance company (deductible, coinsurance, non-covered services). (Note: card information will be stored securely on our server).

Type of card (VISA, MC, Discover, Am Express): _____

Card #: _____

Expiration: _____

Is billing address same as home address?: _____

Signature: _____

Date: _____

- I request that Wellspring Family Medicine, LLC send me a bill for any balance due after my claim is processed by my insurance company (deductible, coinsurance, non-covered services).

I agree to pay the full balance owed **within 10 days of receiving the bill.**

I understand that there will be a penalty of \$10/month charged to my account if I fail to pay on time. I understand that if the bill is not paid within 90 days, my account will be sent to collections and I could be terminated from the practice.

Signature: _____

Date: _____

Patient Name: _____

DOB: _____