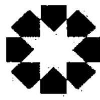


Complete
Family Medicine
A service of Hannibal Regional

Office Use Only:
EPM ______

Authorization to Release Medical Information

For purpose of reimbursement, Complete Family Medicine is hereby authorized and directed to disclose all or any part of the medical record to my employer, my insurance companies, the Health Care Financing Administration and its agents, Medicaid, or any other agencies as may be necessary to verify or process any and all claims for insurance coverage for third party reimbursement. This Clinic may also release information as may be necessary for continuation of care.

Insurance Assignment and Consent to Treatment

The undersigned hereby assigns all monies payable or to be paid by any insurance company(ies), individual(s), corporation(s), or from any source whatsoever for services rendered to the below patient of Complete Family Medicine a service of HRHS. I hereby request and consent to receive treatment from this Hannibal Regional Health System Service. I understand that this clinic is staffed by a healthcare team, which may include a physician(s), nurse practitioner(s), nurses and technicians. I freely accept care from this healthcare team and acknowledge the establishment of the provider-patient relationship. I further understand that this healthcare team will provide information and/or care including but not limited to, medical history, physical examination, assessments of health status, laboratory and diagnostic testing, emergency procedures, suturing, prescription medications, and immunizations; however, I maintain the right to make all decisions regarding my care. This consent is to remain in effect until I revoke it in writing. I understand that I have the right to revoke this consent at any time.

Agreement to Pay

In consideration of services provided, each of the undersigned (including the person signing as a representative for the patient is the patient, is his/her spouse, unemancipated child or other lawful dependent) agrees to pay all charges of Complete Family Medicine and independent contractors. Each bill is due and payable upon presentation or mailing of the same to either the patient or any of the undersigned. If any bill becomes delinquent, the undersigned agrees to pay all collection agency fees, all attorney's fees and all other collection expenses incurred by Complete Family Medicine and/or the independent contractors. If suit is filed to enforce collection, it may be filed in the county where the agreement is being signed and entered into.

Initial Here: ________ I acknowledge that I have read the Financial Policy that is posted and understand my financial obligations regarding my visit(s) to Complete Family Medicine. A copy of the policy is available upon request.

PATIENT RIGHTS

I acknowledge that I have received a copy of my patient rights. (Please initial) ___________
Do you have an Advance Healthcare Directive? (Durable POA, Living Will) ☐ Yes ☐ No
A copy of my Advanced Healthcare Directive will be provided to the clinic? ☐ Yes ☐ No
Would you like to receive information on Advance Healthcare Directive? ☐ Yes ☐ No

---

HIPAA DISCLOSURE

I give CFM permission to share or discuss my health information (including your condition, plan of care, labs, x-rays, appointments etc.) with the following family, friends or others who will be involved in my care or payment for care. If releasing information to anyone, including those listed below, for purposes other than for care or payment, I understand I will be required to sign a separate Medical release form.

Full Name: ________________________________ Relationship to Patient: ________________
Full Name: ________________________________ Relationship to Patient: ________________
Full Name: ________________________________ Relationship to Patient: ________________
Full Name: ________________________________ Relationship to Patient: ________________

By signing below, I acknowledge that I have received a copy of Complete Family Medicine's Notice of Privacy Practices and the Patient Rights and Responsibilities Brochure. The Notices describe how my health information may be used or disclosed and my rights and responsibilities as a patient of CFM/HRHS. I understand that I should read them carefully. I am aware that the Notices may be changed at any time and that I may obtain a revised copy of the Notices by contacting CFM/HRHS.

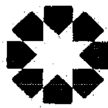
I CERTIFY THAT I UNDERSTAND AND AGREE TO THE PROVISIONS CONTAINED WITHIN THIS AGREEMENT

PRINT Patient's Name: ________________________________ **Date of Birth**: ____________

PATIENT/GUARDIAN SIGNATURE: ____________________________ **Today's Date**: ____________
Witness (CFM Representative): ____________________________ Today's Date: ____________

If you are signing for the patient, please complete the following information:

Name: ________________________________ Date of Birth: ____________
Relationship to the Patient: ________________________ Phone: ____________



New Patient Registration Form

Today's Date: ____________

PATIENT INFORMATION

Patient Name – **Last:** ______________ **First:** ______________ **MI:** ________
SSN of Patient: ______________ **Date of Birth:** ______________ **Sex:** (M/F)________
Address: ______________ **City, State:** ______________ **Zip Code:** ________
Phone #: ______________ **Email:** ______________
Race: ______________ Ethnicity: ______________ Language: ________

Are you currently employed? ☐ Yes ☐ No Employer's Name: ______________
Employer's Address: ______________ Employer's Phone: ______________
In case of emergency, name a friend or relative not living with you: ______________
Address: ______________ City: ______________ State: ________ Zip Code: ________
Relationship: ______________ Phone: ______________ **Who is your primary care physician? :** ______________

RESPONSIBLE PARTY

Name (Last, First, M.I.): ______________ Phone: ________ Cell: ________
Address: ______________ Date of Birth: ______________
City: ______________ State: ________ Zip Code: ________ Sex (M/F): ________
SSN#: ______________ Relationship to Patient: ______________
Is the responsible party currently employed? ☐ Yes ☐ No Employer's Name: ______________
Employer's Address: ______________ Employer's Phone: ______________

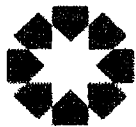
Do you have health insurance? ☐ Yes ☐ No
Are you the carrier of the insurance? ☐ Yes ☐ No if no, please complete insured's information.

INSURED'S INFORMATION

Name (Last, First, M.I.): ______________ Phone: ________ Cell: ________
Address: ______________ Date of Birth: ______________
SSN#: ______________ Employer: ______________ Relationship to Patient: ______________
Name of Insurance: ______________ **Policy #:** ______________ **Group #:** ________

Do you have secondary/supplemental health insurance? ☐ Yes ☐ No
Are you the carrier of the insurance? ☐ Yes ☐ No if no, please complete insured's information or (same as above).
Name (Last, First, M.I.): ______________ Phone: ________ Cell: ________
Address: ______________ Date of Birth: ______________
SSN#: ______________ Employer: ______________ Relationship to Patient: ______________
Name of Insurance: ______________ **Policy #:** ______________ **Group #:** ________

Patient/Guardian Signature: ______________ Date: ______________
Witness (CFM Representative): ______________ Date: ______________



Complete
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A service of Hannibal Regional

Office Use Only
Immunization: ______ Preventative: ____
Meds Reviewed______
(Circle one)
List   Verbal   Pharmacy

Patient Name: ____ Date of Birth: ____________________

Why are you seeing us today? ____

____

Please Circle if you are experiencing any of these symptoms:

Constitutional:
Excess Fatigue, fever, night sweats

HEENT:
Eye discharge and vision loss
Ear Drainage, hearing loss and nasal drainage

Respiratory:
Cough, shortness of breath and wheezing

Cardiovascular:
Chest pain, pain in your legs while walking, and irregular heartbeat/palpitations

Gastrointestinal:
Abdominal Pain, constipation, diarrhea and vomiting

Genitourinary/Reproductive:
Pain with urination, blood in your urine, increased urinary frequency
MEN: Penile discharge **WOMEN**: Pain with menstruation, excessive bleeding, vaginal discharge

Metabolic/Endocrine:
Cold intolerance, heat intolerance, increased drinking and increased appetite

Neuro/Psychiatric:
Trouble Walking
Psychiatric Symptoms

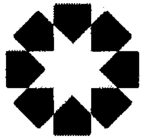
Dermatologic: Itch, Rash

Musculoskeletal:
Bone/joint symptoms and muscle weakness

Hematology:
Bleeding and easy bruising

Immunology: Environmental allergies, drug allergies

M99.O OA, F E, RR RL, SR SL
M99.01 C 2345 6 7, F E RRRL, SR SL
M99.02 T 1 2 3 4 5 6 7 8 9 10 11 12 N F E, RR RL, SR SL
M99.03 L 2 3 4 5, NF E, RR RL, SR SL
M99.04 S L R on L R or L R Shear-sup, inf
M99.05 P L R, ant post shear-sup
M99.06 LE
M99.07 UE
M99.08 Rib L R, 1 2 3 4 5 6 7 8 9 12 inhaled exhaled
M99.09 Other



Complete
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Date: ______________
Provider's Initials: ________
Abstracted By: ________

ADULT HEALTH HISTORY

Patient's Full Name: ________________________ ☐ Male ☐ Female DOB ___/___/_____

Marital Status: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

Previous or Referring Doctor: ______________________________

Date of Last Physical Exam: ______________________________

PERSONAL HEALTH HISTORY

Have you ever had the following as a child:

Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

IMMUNIZATIONS (with Dates)

Tetanus: ____________ Pneumonia: ____________ Hepatitis: ____________

Chicken Pox: ____________ Influenza: ____________ MMR: ____________

LIST ANY MEDICAL PROBLEMS THAT OHER DOCTORS HAVE DIAGNOSED:

____

____

____

____

SURGERIES:

Year Reason Hospital

____

____

____

____

____

OTHER HOSPITALIZATIONS:

Year Reason Hospital

____

____

____

____

____

Have you ever had a blood transfusion? NO YES

LIST ANY AND ALL MEDICATIONS (include all prescription, vitamins, supplements, inhalers, etc)

Name of the Drug	Strength	Frequency Taken

____
____
____
____
____
____
____
____
____

ALLERGIES TO MEDICATIONS and/or MATERIALS:

Name of the Drug/Material	Reaction that you had

____
____
____

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise:
☐ Sedentary (no exercise) ☐ Mild Exercise (climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (work or recreation, less that 4x/week for 30 min)
☐ Regular Vigorous Exercise (work or recreation 4x/week for 30 min)

Diet:
Number of meals you eat in an average day? ______________
Are you Dieting? NO YES
If yes, are you on a physician prescribed medical diet? NO YES
Rank of Salt Intake: HI MED LOW
Rank of Fat Intake: HI MED LOW

Caffeine: NONE COFFEE_____ cups/day TEA____cups/day COLA ____cups/day

Alcohol:
Do you drink alcohol? NO YES
If Yes, what kind? ____________ How many drinks per week? ______
Are you concerned about the amount you drink? NO YES
Have you considered stopping? NO YES
Have you ever experienced blackouts? NO YES
Are you prone to "binge" drinking? NO YES
Do you drive after drinking? NO YES

Tobacco:
Do you use tobacco? NO YES
How long in years? ____________
Cigarettes – Pks/day ______ Chew - #/day______ Pipe - #/day _______ Cigars - #/day ______

Drugs:
Do you currently use recreational or street drugs? NO YES
Have you ever given yourself street drugs with a needle? NO YES

Sex:
Are you sexually active? NO YES
If yes, are you trying for pregnancy? NO YES
If not trying for a pregnancy, list contraceptive or barrier method used: ____________
Any discomfort with intercourse? NO YES

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse.

Would you like to speak with your provider about your risk of this illness? NO YES

Personal Safety:

Do you live alone?	NO	YES
Do you have frequent falls?	NO	YES
Do you have vision or hearing loss?	NO	YES
Do you have an Advance Care Directive and/or Living Will?	NO	YES
Would you like information on the preparation of these?	NO	YES

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse.

Would you like to discuss this issue with your provider? NO YES

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			
Siblings M/F			
M/F			
M/F			
M/F			
M/F			
M/F			
M/F			
M/F			

	Age	Age at Death	Significant Health Problems or Cause of Death
Children M/F			
M/F			
M/F			
M/F			
M/F			
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

MENTAL HEALTH

Is stress a major problem for you?	NO	YES
Do you feel depressed?	NO	YES
Do you panic when stressed?	NO	YES
Do you have problems with eating or your appetite?	NO	YES
Do you cry frequently?	NO	YES
Have you ever attempted suicide?	NO	YES
Have you ever seriously thought about hurting yourself?	NO	YES
Do you have trouble sleeping?	NO	YES
Have you ever been to a counselor?	NO	YES

WOMEN ONLY

Age at onset of menstruation: ____ Date of last menstruation: ____/____/_______

Period every ______ days.

Heavy periods, irregularity, spotting, pain or discharge? NO YES

Number of pregnancies _______ Number of Live births __________

Are you currently pregnant or breastfeeding?	NO	YES
Have you had a D&C, hysterectomy or cesarean?	NO	YES
Any blood in your urine?	NO	YES
Any problems with control of urinations?	NO	YES

Patient Name: ______________________ DOB: ________________ Provider Initials: __________

WOMEN ONLY (cont.)

Any hot flashes or sweating at night?	NO	YES
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	NO	YES
Have you experienced any recent breast tenderness, lumps or nipple discharge?	NO	YES
Date of last pap and/or rectal exam? ____/_____/_____		

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times? ___________	NO	YES
Do you feel pain or burning with urination?	NO	YES
Any blood in your urine?	NO	YES
Do you feel burning discharge from penis?	NO	YES
Has the force of your urination decreased?	NO	YES
Have you had any kidney, bladder or prostate infections Within the last 12 months?	NO	YES
Do you have any problems emptying your bladder completely?	NO	YES
Any difficulty with erection or ejaculation?	NO	YES
Any testicle pain or swelling?	NO	YES
Date of last prostate and/or rectal exam? ____/____/_____		

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

- ☐ Skin ___________________
- ☐ Head/Neck ______________
- ☐ Ears ___________________
- ☐ Nose ___________________
- ☐ Throat __________________
- ☐ Lungs __________________
- ☐ Back ___________________
- ☐ Intestinal ______________
- ☐ Bladder ________________
- ☐ Bowel _________________
- ☐ Circulation ____________
- ☐ Chest/Heart ____________

Recent changes in:

- ☐ Weight ________________
- ☐ Energy Level ___________
- ☐ Ability to Sleep _________

Other Pain/Discomfort: ____

____

____

____

____

What other doctors, specialists, or alternative healthcare providers do you currently see or have you seen in the past?

____

____

____

____

____

____

____

Please remember that the following recommendations are very important to maintain your health.

* When in a car, wear your safety belt at all times
* While riding a motorcycle or bicycle, wear a helmet.
* Always have functional smoke detectors and fire extinguishers in your home.
* If you own a firearm, make sure that it is accessible only to you, Take every precaution to ensure that children do not have access to a loaded firearm.
* Keep the firearm and ammunition in separate locations.

Patient Name: ______________________ DOB: ________________ Provider Initials: __________