Patient Registration

Patient Name: _____Social Security #_____
Last First MI
Street Address:_____City:_____State:_____Zip:____

Home Ph:_____Work Ph:_____Cell Ph:_____

Date of Birth:_____Age:_____Sex:_____ Marital Status:_____

Allergies:_____

(Under 18)
Mother's/Wife Name: _____Social Security #_____
Last First
Street Address:_____City:_____State:_____Zip:____

Home Ph:_____Work Ph:_____Cell Ph:_____

Date of Birth:_____Age:_____Sex:_____ Marital Status:_____

(Under 18)
Father's/Husband Name: _____Social Security #_____
Last First
Street Address:_____City:_____State:_____Zip:____

Home Ph:_____Work Ph:_____Cell Ph:_____

Date of Birth:_____Age:_____Sex:_____ Marital Status:_____

Insurance:_____Phone:_____

Policy Holder's Name_____Relationship to Patient:_____Sex:_____

DOB:_____ Policy Holder's Employer:_____Phone:_____

Subscriber ID#_____Group:_____

Secondary Insurance:_____Phone:_____ __

Policy Holder's Name_____Relationship to Patient:_____Sex:_____

DOB:_____ Policy Holder's Employer:_____Phone:_____

Subscriber ID#_____Group:_____

Emergency Contact Name:_____Relationship to Patient:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

I hereby assign medical benefits due to me to be paid to Midwest Family Practice, PLC. I hereby consent to the release of medical information necessary to process my insurance claims and to any other doctor for continuation of my medical care. I understand that a photocopy of this release is as valid as the original.

_____ _____
Signature of Patient, Parent or Guardian Date

Midwest Family Practice
12640 12 Mile Road
Warren, MI 48093
(586) 751-2020

PATIENT HISTORY

Patient Name _____ Date _____

Address _____ Phone # _____

Social Security # _____ Birth Date _____

Requesting Physician _____

Primary Family Physician _____

Address _____ Phone # _____

EMPLOYMENT INFORMATION

Occupation _____ Retired ☐ Yes ☐ No

Employer _____ Work Phone # _____

Employer's Address _____

_____

Are you presently working? ☐ Yes ☐ No

If not, please provide last day you worked full time _____

SPOUSE'S INFORMATION

Spouse's Name (*if married*) _____

Spouse's Social Security # _____ Birth Date: _____

Spouse's Employer _____ Work Phone # _____

Employer's Address _____

_____

PAST MEDICAL HISTORY

High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Blood Disorder (*Thin Blood*)	☐ Yes	☐ No

Please list all illnesses / medical conditions / hospital admissions below

_____

_____

_____

_____

Please list all past surgeries in chronologic order

Name of Surgery	Name of Surgeon / Hospital	Date of Surgery

MEDICATIONS

Please list all the medications you are currently taking including vitamins, nutritional supplements, herbal remedies and over the counter medications.

Name of Medication	Dosage or Strength	How Often Each Day

ALLERGIES Please list allergies to all medication, foods, dyes or materials.

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS Are you currently experiencing any of the following?

Constitutional	Fever	☐ Yes	☐ No	**GUI**	Urinary Urgency	☐ Yes	☐ No
	Weight Loss	☐ Yes	☐ No		Incontinence	☐ Yes	☐ No
	Weight Gain	☐ Yes	☐ No		Sexual Difficulty	☐ Yes	☐ No
Eyes	Blurred Vision	☐ Yes	☐ No	**Muscular/**	Joint Pain	☐ Yes	☐ No
	Double Vision	☐ Yes	☐ No	**Skeletal**	Back Pain	☐ Yes	☐ No
	Wear Glasses	☐ Yes	☐ No		Neck Pain	☐ Yes	☐ No
ENT	Hearing Loss	☐ Yes	☐ No	**Skin**	Rashes	☐ Yes	☐ No
	Sinusitis	☐ Yes	☐ No		Bruising	☐ Yes	☐ No
	Neck Swelling	☐ Yes	☐ No		Keloids	☐ Yes	☐ No
CVS	Chest Pain	☐ Yes	☐ No	**Neurological**	Stroke	☐ Yes	☐ No
	Palpitation	☐ Yes	☐ No		Seizures	☐ Yes	☐ No
	Heart Attack	☐ Yes	☐ No		Headaches	☐ Yes	☐ No
					Paralysis	☐ Yes	☐ No
GI	Constipation	☐ Yes	☐ No		Weakness	☐ Yes	☐ No
	Fecal Incontinence	☐ Yes	☐ No		Where? _____		
	Jaundice	☐ Yes	☐ No		Numbness	☐ Yes	☐ No
					Where? _____		
Respiratory	Shortness of Breath	☐ Yes	☐ No	**Psychiatric**	Depression	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No		Other Psychiatric illness	☐ Yes	☐ No
	Coughing	☐ Yes	☐ No				
	Asthma	☐ Yes	☐ No	**Blood Disorder** (easy bruising, thin blood)		☐ Yes	☐ No

Are you ☐ Right handed ☐ Left handed

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If so, how many_____

Do you smoke? ☐ Yes ☐ No If so, _____packs per day how long_____

Do you drink? ☐ Yes ☐ No If so, how many drinks per day_____

Do you use drugs? ☐ Yes ☐ No If yes, please indicate type and how often_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY

High Blood Pressure	☐ Yes	☐ No	**Heart Attack**	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Seizures**	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	**Psychiatric/Emotional Problems**	☐ Yes	☐ No

	IF LIVING		*IF DECEASED*	
Relationship	*Age*	*Health Problems*	*Age at Death*	*Cause of Death*
Mother				
Father				
Grandparents				
Grandparents				
Aunt / Uncle				
Aunt / Uncle				
Sister / Brother				
Sister / Brother				
Children				

Patient Signature _____ Date _____

Physician Signature _____ Date _____

Midwest Family Practice
12640 E. 12 Mile Road
Warren, MI 48093
586-751-2020
586-751-7872 fax

FINANCIAL POLICY

Thank you for choosing our providers for your health care needs. If you have medical insurance we want to assist you in receiving your maximum allowed benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

1. Payment is due at the time of service. This includes all co-pays and deductibles required by your insurance plan. Co-pays that are not paid at the time of treatment will incur an additional $5.00 administrative fee.

2. While the filing of insurance claims is a service that we provide to our patients, all charges are your responsibility from the date of service. Any portion of the bill that is not paid by your insurance, for whatever reason, is your responsibility and arrangements for prompt payment are required.

3. Patient account balances must be paid within 30 days. A rebilling charge of $3.00 is added each month to unpaid balances over 30 days old.

4. Accounts without payment for greater that 90 days may be sent to a collection agency. Any costs associated with the agency will be your responsibility in addition to the original delinquent balance.

5. Returned check fee is $75.00.

6. Appointments that cannot be kept must be cancelled 24 hours before the appointment. Those that are not cancelled within the requested timeframe, or are missed altogether, may be charged the rate of an office visit.

We realize that temporary financial problems may occasionally affect timely payment of your account. If such problems arise, please let us know immediately and we will be happy to assist you in arranging a suitable payment plan.

I, (print name)_____, have read the Financial Policy of Midwest Family Practice, PLC. I understand and agree to all terms of the policy as stated.

_____ _____
Signature of Patient or Responsible Party Date

Patient's name if other than above_____ _____
Please print

Midwest Family Practice
12640 E 12 Mile Road
Warren, MI 48093
586-751-2020
586-751-7872

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ A COPY OF MIDWEST FAMILY PRACTICE NOTICE OF PRIVACY PRACTICES LITERATURE.

_____

NAME (PLEASE PRINT)

_____

SIGNATURE DATE

_____

WITNESS DATE

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT:

ON_____,_____.

PRESENTED THIS ACKNOWLEDGEMENT TO_____.

THE PATIENT HAS REFUSED TO PROVIDE THE SIGNATURE REQUESTED:

DOCUMENTATION OF PATIENT RECEIPT OF A COPY OF PRIVACY PRACTICES OF MIDWEST FAMILY PRACTICE:

ON_____,_____ RECEIVED A COPY

THE PRIVACY PRACTICES OF MIDWEST FAMILY PRACTICE BY,_____.

A STAFF MEMBER OF MIDWEST FAMILY PRACTICE.