WELCOME TO
Family First Health Center

Delicia M. Haynes, MD

Patient Full Name (Printed): _____

Have you or anyone in your family been a patient of the doctor? YES NO

Who?_____Relationship_____

Whom may we thank for referring you to our office? _____

How did you find out about us? _____

How would you describe your ideal clinic? _____
_____

How would you describe your ideal Doctor? _____
_____

Patient Medical History Form

(Please complete this form 1st and hand into receptionist when finished)

List medications you are currently taking
(Include birth control pills and non-prescriptive items such as vitamins, aspirin, herbs etc.)

1. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
2. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
3. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
4. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
5. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
6. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
7. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
8. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
9. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____
10. _____ **Dose**_____ **How Many Tablets or Capsules** _____ **How Often**_____

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

Other:_____

Please list any medication allergies and reactions:_____
_____

Past Surgical History: No___ Yes____ (Please circle all that apply and write in year)

Year	Type of Surgery

Family Member	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Children (List Genders & Ages)			
Siblings (List Genders & Ages)			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Patient Social History (Please check all that apply)
Use of Alcohol: Never__ Rarely__ Moderate__ Daily__ How many Drinks per Week_____ Month_____

Use of Tobacco: Never__ Daily__ Current # Packs/day_____ Previously, but quit_____ Year_____

Review of Systems Do you currently (**TODAY**) have any of the following? (Check all that apply)

Y__N__ Headaches Y__N__ Chest Pain
Y__N__ Diarrhea Y__N__ Shortness of Breath
Y__N__ Constipation Y__N__ Fever
Y__N__ Blood in Stool Y__N__ Vomiting
Y__N__ Painful Urination

WOMEN ONLY (Check all that apply)

Last PAP Smear Date:_____ Normal Y / N

Last Mammogram Date:_____ Normal Y / N

Last Bone Density Date:_____ Normal Y / N

Reason for Today's Visit:

_____

_____

_____

Life Style Questions

*On Average how many hours of UNINTERRUPTED sleep do you get per night? _____

*Do you have a religious affiliation (If so which religion)?_____

*What is the most active thing you do, and how often do you do it?

_____
_____

*What kind of work do you do and is there any history of exposure to chemicals?

_____
_____

*What does an average daily meal consist of?

_____
_____
_____

3 Health Wishes	**3 Health Fears**
1._____	1._____
2._____	2._____
3._____	3._____

REGISTRATION FORM (PLEASE PRINT) **TODAY'S DATE** /___/_____

Please allow us to photocopy your ID Card & Insurance card(s)

Patient's Full Name_____Age _____

Patient's Social Security #_____Date of birth_____Sex_____

Marital Status (circle one) Minor Single Married Widowed Divorced Separated

Home Address _____

Street City State Zip

Home Telephone_____ Cell Phone_____

Your Email Address: _____

Patient's Occupation_____Patient's employer _____

Patient's Employer Address_____Phone_____

Name of Spouse_____Spouse's Employer_____Phone_____

Name of Relative or Friend not living with patient_____Phone_____

If patient is a MINOR, fill in responsible parent or guardian:

Mother's Name_____Mother's Employer _____

Mother's Date of Birth_____Social Security #_____Work Phone _____

Father's Name_____Father's Employer _____

Father's Date of Birth_____Social Security #_____Work Phone _____

Father's Address _____

Dissemination of Medical Information:

To whom may we, as your health care provider(s), release information about your medical condition(s)?

_____	_____ Relationship
_____	_____ Relationship
_____	_____ Relationship
_____	_____ Relationship

Other Physicians who participate in your care from whom you give Family First Health Center

Permission to Request Medical Records

Physician Name	Practice Name/Phone	Specialty

_____ _____

Signature of Patient or Responsible Party Date Signed

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations. Due to the nature of our availability some patients choose to send emails to the staff. E-mail is not a secure mode of communication and we can not guarantee the security of information sent via email. We do offer a secure patient portal. Emergency messages should not be sent through either medium. If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. **You have the right to review our entire notice of privacy policies upon request**.

Please sign this form to acknowledge that you have read this notice of our privacy policies.

Patient Name: _____ Signature: _____

If minor, signature of parent or guardian: _____ Date: _____

Financial Policy

This is an agreement between Family First Health Center and the patient named on this form. In this agreement the words "you", "your", and "yours" means the patient. The word "account" means the account which has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Family First Health Center. By executing this agreement, you are agreeing to pay for all services received.

Monthly Statement /Charges to your account: If you have a balance on your account, we will send you a monthly statement. Future visits would then need to be paid at the time of service or you may be discharged from the practice. A financial charge will be imposed on each item of your account which has not been paid by the due date.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency you agree to pay all of the collection costs which are incurred.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by 11:59pm on the due date.

Payment Options

*Please select from one of the following:

Direct Primary Care

☐ **Access Wellness Membership**

☐ **Premier Concierge Membership**

Healthy Employee Program

☐ _____
(Employer Name)

Other:

☐ **Self Pay**

Patient's Name _____
Patient Acknowledgement (Signature)

Responsible Party (if not the patient) _____

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any of the portions not paid by your insurance.

Additional Information and Fees:

• There will be a $35.00 fee assessed for all checks returned unpaid by banks.

• Prescription renewals are best completed during your office visit. If you need a prescription refill between office visits, we will provide this within 48 business hours. Prescription refills will be processed during office hours only. You may also use our online prescription refill request at any time.

• We request at least a 24 hour advance notice if you will be unable to keep your scheduled appointment (please call as (386) 492-1064 as soon as possible). Our policy is to charge $60.00 for missed appointments unless cancelled at least 4 hours in advance. This fee must be paid before a new appointment is scheduled.

• Completing disability insurance forms paper work unrelated to the medical visit, and employer forms is not a medical service and is not paid by insurance. There is a fee for completing these forms. Please allow at least one week for completion. Please provide a pre addressed and stamped envelope for mailing or a FAX number if requested.

• If you would like a copy of your medical records there is a $40 fee. There is no fee for sending medical records via fax for continuation of care, but a legal release will be required. Please allow at least one week for records to be released. Any records sent to any non-medical related parties must send a $40.00 payment upon receipt on an invoice.

Patient's Name _____
Patient Acknowledgement (Signature)

_____/_____/_____
Date

_____
Name

Cosmetic Interest Questionnaire

☐ YES, I am interested in Physician Treatments that promote Healthy and Youthful Skin. Please Check areas of concern below:

- ☐ Medical grade Skin Care Products
- ☐ Aging Skin
- ☐ Brown Spots
- ☐ Thinning lips, lines around mouth
- ☐ Fine lines, wrinkles
- ☐ Permanent hair removal

☐ No, I am not interested in Cosmetic Treatment of my skin at this time

☐ Please contact me with special offers and events around anti-aging procedures

E-Mail: _____ Phone:_____

FOR OFFICE USE ONLY

Discussion

_____

_____

_____

_____ Menus Given

_____ Appt Booked

_____ Call Made

_____ Date/Outcome

_____ E-Mail Added