Dothan Medical Associates, P.C.
Patient Registration

FOR OFFICE USE ONLY
ID# _____

REASON FOR VISIT: _____ PREFERRED PHARMACY: _____

WHAT DOCTOR REFERRED YOU TO US: _____ DATE _____

NAME		SEX ❑ M ❑ F	AGE	BIRTHDATE	MARITAL STATUS M S D W
MAILING ADDRESS		SOCIAL SECURITY #		DRIVER'S LICENSE #	
CITY	STATE ZIP	❑ EMPLOYED	❑ RETIRED	❑ DISABLED	❑ STUDENT
EMAIL ADDRESS		EMPLOYER OR SCHOOL		OCCUPATION	
HOME PHONE	CELL	WORK		PRIMARY NUMBER	

WHICH ONE OF THE ABOVE NUMBERS CAN WE USE TO LEAVE MESSAGES REGARDING APPOINTMENT REMINDERS:

SPOUSE OR GUARDIAN INFORMATION:

NAME		RELATIONSHIP TO PATIENT	SSN #	BIRTHDATE
ADDRESS		OCCUPATION		
CITY		EMPLOYER		
HOME PHONE	WORK OR CELL PHONE	CITY	STATE	ZIP

EMERGENCY CONTACT OTHER THAN SPOUSE (REQUIRED):
Name Relationship Phone

FINANCIAL POLICY:

COMMERCIAL INSURANCE:
Payment is expected at the time of service unless we are a provider for your insurance company. We currently have provider contracts with Medicare, BCBS PMD/PPC, Heathsource PPN (formerly Provident PPN), Perdue, Beechstreet, CCN, TriCare, and OneSource MedNet. It is our policy that all co-pays and/or deductible amounts are due and expected at the time of service.

Credit Cards accepted: VISA MASTERCARD

INSURANCE INFORMATION:

Primary _____ Secondary _____

Please present the following information to the Receptionist to make a photocopy for your chart:

All Insurance Cards Your Driver's License

AUTHORIZATIONS:

INSURANCE AND PAYMENT AUTHORIZATIONS:
I authorize **Dothan Medical Associates, P.C.**, to release any medical information requested by my health insurance carrier, Medicare or any other third-party payers. **Dothan Medical Associates, P.C.**, may contact my insurance company or health plan administrator to obtain pertinent financial information concerning coverage and payments under my policy. I hereby authorize payment of insurance benefits be made on my behalf to **Dothan Medical Associates, P.C.**, and assign benefits to the physician indicated on the claim.

I understand that I am responsible for any co-pays or deductibles as defined by my insurance policy, and for any "non-covered" services of my consent if deemed necessary. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collection, attorney fees, and/or court costs; if such be necessary. I waive now and forever my rights of exemption under the laws of the constitution of the State of Alabama and any other state.

I give **Dothan Medical Associates, P.C.**, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message) for the purpose of treatment, insurance or payment. I authorize **Dothan Medical Associates, P.C.**, to release all information to my referring physician and/or primary care physician.

I hereby give authorization for treatment to my physician(s) at **Dothan Medical Associates, P.C.**, and give permission to disclose my protected health information in order to carry out treatment, payment, and other healthcare operations.

DATE_____ **SIGNATURE** _____
(PATIENT OR RESPONSIBLE PARTY)

CURRENT MEDICATION LIST

(Include any vitamins or non-prescription medicines)

NAME OF MEDICATION	DOSAGE (ex. mg, mcg)	DIRECTIONS

ALLERGIES: _____

_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems that you are currently having at time of visit.

Date of last mammogram _____ Date of last eye exam _____ Date of last chest x–ray _____

Date of last Tuberculosis Test _____ Date of last bone densitometry _____ Date of last foot exam _____

Constitutional

- ❑ Recent weight gain
  amount _____
- ❑ Recent weight loss
  amount _____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat

- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Loss of taste
- ❑ Dryness of mouth
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular

- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ High blood pressure
- ❑ Heart murmurs

Respiratory

- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting of blood or coffee ground material
- ❑ Stomach pain relieved by food or milk
- ❑ Jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools
- ❑ Heartburn

Genitourinary

- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, “smoky” urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For Women Only:

Age when periods began:_____

Periods regular? ❑ Yes ❑ No

How many days apart? _____

Date of last period? ____/____/____/

Date of last pap?____/____/____

Bleeding after menopause? ❑ Yes ❑ No

Number of pregnancies? _____

Number of miscarriages? _____

Musculoskeletal

- ❑ Morning stiffness
  Lasting how long?
  _____ Minutes _____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Joint swelling

List joints affected in the last 6 mos.

_____

_____

_____

_____

_____

Integumentary (skin and/or breast)

- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Muscle spasm
- ❑ Loss of consciousness
- ❑ Sensitivity or pain of hands and/or feet
- ❑ Memory loss
- ❑ Night sweats

Numbness/Tingling

Tremor

Psychiatric

- ❑ Excessive worries
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Agitation
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine

- ❑ Excessive thirst

Hot/Cold Intolerance

Hematologic/Lymphatic

- ❑ Swollen glands
- ❑ Tender glands _____
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Transfusion/when

Allergic/Immunologic

- ❑ Frequent sneezing
- ❑ Increased susceptibility to infection

Patient’s Name _____ Date _____ Physician Initials _____

DOTHAN MEDICAL ASSOCIATES, P.C.

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTH CARE INFORMATION

I, _____ , give permission to my physician(s) at **Dothan Medical Associates, P.C.** to use and disclose my personal health information to carry out treatment, payment, and other health care operations. I understand that **Dothan Medical Associates, P.C.** works hard to protect my privacy and preserve the confidentiality of my personal health information. I realize that employees who work for **Dothan Medical Associates, P.C.** may use and see my information, but they may use it only as permitted in this form.

This information can include spoken or written facts about my health or payment benefits as permitted under the law. It can include copies of records from my health care providers or health plans about my health care. It also gives permission for any listed persons I designate below to have access to my medical information.

This disclosure becomes effective April 14, 2003 and will continue unless it is cancelled, changed or amended by my appointed legal representative, or myself. I realize I may stop or change the names listed below by notifying my doctor in writing that I do not want them to know or share my private information. If I decide to revoke this consent, I understand that **Dothan Medical Associates, P.C.** does not have to provide any further care services to me depending on the circumstances.

I know that my private healthcare information will be protected by **Dothan Medical Associates, P.C.** and every safety precaution will be taken to ensure that my personal health information is kept private and confidential. My signature below indicates that I agree to allow Dothan Medical Associates, P.C. to use and disclose my personal health information to carry out treatment, payment, and health care operations.

_____ _____ _____

Signature of Patient or Authorized Person **Date of Birth (Patient)** **DATE**

_____ _____

Printed Name of Above **Relation to Patient**

PLEASE CHECK ANY/ALL OF THE FOLLOWING WAYS WE ARE PERMITTED TO LEAVE PATIENT INFORMATION FOR YOU:

❑ Information regarding tests results may be left on my_____home phone_____work phone_____other_____
❑ Information regarding appointments may be left on my_____home phone_____work phone_____other_____
❑ I do not wish for any of my private information to be left on my home phone, work phone, or other phone.

*** The names listed below are permitted to share and know my health information.**

_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____
_____ RELATION:_____ PHONE:_____

* **The names given above mean we can discuss results of ordered tests, labs, medication changes, appointments, or other things pertaining to your health care. For example, if your daughter is usually the contact person for you, please be sure to list her.**