FAMILY MEDICAL CENTER P.C
225 SOUTH PINE ST. SUITE 20
SEYMOUR, IN 4727

PATIENT INFORMATION

Please be sure every space is filled out. If it does not pertain to you, please put N/A.

Patient's Legal Name (Last, First, Middle Initial; maiden name if applicable)		
Address (Street, Apt. #)		Date of Birth
City, State	Zip	Home Phone #
Social Security #		Cell Phone #
Patient's Employer Name		Work Phone #
Employers Address		
Marital Status **Married, Single, Divorced, Widowed**		Sex **M F**
Race (please circle) **White, Black, Asian, More than One**		Hispanic **Y N**
Language of Preference		
Email:		

Responsible Party Name (Last, First, Middle Initial)		
Home Address (Street, Apt. #)		Date of Birth
City, State	Zip	Home Phone #
Social Security #		Cell Phone #
Employer Name		Work Phone #
Insurance Company Name		
Patient's Mother's First Name		
Patient's Mother's Last Name		
Patient's Mother's Maiden Name		

We will require a copy of your current insurance card.

Nearest Relative Not Living With You	Home Phone #
Person Responsible for Medical Bills	

In Case of Emergency, Please Contact	Relationship
Home Phone #	Work Phone #

Please list the name(s) of other persons that may obtain medical information on your behalf:

_____

To assist us in providing the best service possible, please tell us how you heard about our practice:

_____

I authorize Family Medical Center, PC to furnish information to other physicians, insurance carriers and other related entities concerning the illness or medical treatment of my dependent or myself.

I recognize and accept responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. I also hereby assign to the provider(s) all insurance payments for medical services rendered to my dependent or myself, except those services for which I have already paid prior to the filing of the insurance claim on my behalf. If for any reason the account should become delinquent, I agree to pay for all court costs, collection and legal fees, and interest due.

_____

Signature of Patient or Responsible Party Date

Family Medical Center

225 S Pine St. Suite 200 Seymour IN 47274 P (812) 524-3333 F (812)524-3334

Authorization for Release of Medical Information

*Fill all blanks fully and completely to ensure proper handling of your records

*Patient's Name: _____DOB_____

*Address: _____

*City: _____ State: _____ Zip: _____

I undersigned here by authorize:

*Dr. _____ *Address: _____

City: _____ State: _____ *Zip _____
to release the following portions of the medical record of the above named patient.

*(Select only one option)

_____The entire medical record

Or

_____The following specific portion of the medical record_____ for the period of _____to_____.

Release this information to:

*Name of Physician or Institution: _____

*Address_____

*City _____*State: _____ Zip:_____

Via First Choice Direct Message HISP or Second Choice CD

____Bradley S Morin MD:
____Nicholas R Lemming MD:
____John L Fye MD:
____Pamela H Snook-Tidd MD
____Martha J. Shirley DO
____Aaron D. Frey MD
____Samuel C. Borcherding MD

The medical record is needed for the following purpose: _____

I, undersigned, understand that I may REVOKE this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of thirty (30) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I understand that I am giving my permission to release medical information which may include treatment for physical and/or emotional illness, communicable illness, alcohol or drug abuse treatment, and/or HIV, AIDS, OR AIDS-related information. The patient may refuse to sign the authorization and the refusal will not affect their ability to obtain treatment, payment, or eligibility for benefits.

_____ _____
Signature (as designed by law) Date of Signature

_____ _____
Relationship (if other than patient) Witness

Released by_____Date:_____

PEDIATRIC HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Birth History: Birth Weight: _____

Breast Fed / Bottle Fed

Type of Delivery: Vaginal / Cesarean

Yes No

Y / N Born prematurely? If you answered yes, how early? _____

Y / N Complications at time of delivery?

If you answered yes, please provide details: _____

_____

_____

Past Medical History: **If you answer yes to any question, please provide details in the space provided**

Yes No

Y / N Serious injuries or accidents _____

Y / N Surgeries _____

Y / N Hospitalizations _____

Y / N Chickenpox _____

Y / N Eye conditions / Corrective lenses _____

Y / N Problems with ears or hearing _____

Y / N Frequent ear infections or sinus infections _____

Y / N Allergic rhinitis or other allergy _____

Y / N Asthma, bronchitis, broncholitis, or pneumonia _____

Y / N Heart problems or heart murmur _____

Y / N Bladder or kidney infection _____

Y / N Bed-wetting (after 5 years of age) _____

Y / N Chronic or recurrent skin problems(acne, eczema, etc.) _____

Y / N Anemia or bleeding problem _____

Y / N Developmental Delays _____

Y / N ADD / ADHD _____

Y / N Seizures or other neurologic problems_____

Y / N Orthopedic problems/ Sports injuries_____

Y / N Diabetes_____

Y / N Thyroid or other endocrine problems_____

Y / N If female, have menstrual periods started?_____

Y / N If yes, any problems with periods?_____

Y / N Mental Health Concerns / School or Behavioral Problems_____

Y / N Other Infections / Illnesses_____

FAMILY HISTORY – Fill in health information about your family. Check if your ***immediate family*** had any of the following.

Relation	Age	State of Health	Age at Death	Cause of Death		Disease	Relationship to Child (F,M,B,S)
Father						Arthritis, Gout	
Mother						Asthma	
Brothers						Cancer (list type)	
						Depression	
						Diabetes	
Sisters						Heart Disease, Strokes	
						High Blood Pressure	
						Other	

SOCIAL HISTORY: Provide details in the space provided

Yes No

Y / N Pets_____

Y / N Smokers in the home_____

Who does patient live with?_____

If parents are divorced, what is the legal custody status?_____

ALLERGIES
Latex: Y / N
Bees: Y / N
Medications:

MEDICATIONS: Please list any medications the patient takes

Family Medical Center

Patient Acknowledge Form

Patient Acknowledgement of Understanding of Family Medical Center, P.C.'s Privacy Practices

Patient's Name _____ **Date of Birth** _____

SSN: _____ **Previous Name** _____

I understand that the patient's health information is private and confidential. I understand that Family Medical Center, P.C. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's health information.

I understand that Family Medical Center, P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes that law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Family Medical Center, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

Family Medical Center, P.C. may update this Acknowledgement and "Notice of Privacy Practices: If I ask, Family Medical Center, P.C. will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative location.

Family Medical Center, P.C. has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Family Medical Center, P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

Upon signing, I give permission to Family Medical Center, P.C. to leave appointment reminders and brief medical related messages that may require a return call, on my answering machine or voice mail.

My signature below indicates that I have been given the chance to review a current copy of Family Medical Center, P.C.'s "Notice of Privacy Practices".

_____	_____	_____
Patient or legally authorized individual signature	Date	Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

FAMILY MEDICAL CENTER

225 South Pine Street, Suite 200
SEYMOUR, INDIANA 47274
Telephone (812) 524-3333
Fax (812) 524-3334

Patient of Family Medical Center:

The following is our office policy regarding failure of appointments.

1. Failure on first scheduled visit – Dismissal from practice
2. First failure after patient establishment – Verbal warning
3. Second failure – Charged for visit
4. Third failure – Dismissal from practice

Please sign below to acknowledge you have read and understand the above policy.

_____ _____

Patient Signature Date