

Patient Registration Form



2026 N Ewing St
Seymour, IN 47274
Phone: 812-524-3333
Fax: 812-524-3334

Patient Information	Patient Information:				
	Last Name:		First Name:		M.I.:
	Preferred Name or Nickname		Maiden Name (if applicable)		
	Mailing Address:				
	City/State/Zip:				
	Home Phone:		Cell Phone:		Work Phone:
	Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell				
	Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Identify As: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Social Security #:			Relationship to Patient:	
	Email Address:			Emergency Contact Name:	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed			Emergency Contact Phone #:		
Employer Name:			Nearest Relative Not Living With You:		
Employer Address:			Phone #:		
Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:				
	Last Name:			First Name:	
	Date of Birth:		Social Security #:		Phone:
	Address of Person Responsible:				
	City/State/Zip:			Relationship to Patient:	
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):				
	List name(s) of other persons that may obtain medical information on your behalf:				
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline			Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Other <input type="checkbox"/> Spanish		Patient's Mother's Name (First, Last):		Patient's Mother's Maiden Name:
	Please tell us how you heard about our practice: <input type="checkbox"/> Internet/Social Media <input type="checkbox"/> Referral <input type="checkbox"/> Other _____				
Insurance Information	Primary Medical Insurance		Secondary Medical Insurance		
	Ins. Co. Name		Ins. Co. Name		
	Policy Holder Name:		Policy Holder Name:		
	Policy Holder's Date of Birth:		Policy Holder's Date of Birth:		
	Policy Holder's Social Security #:		Policy Holder's Social Security #:		
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:		
<i>We will require a copy of your current insurance card.</i>					

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 dependents 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, attorney fees, and a \$75 fee to offset the collection costs if the account is referred to a collection agent.

Signature of patient or legally authorized individual: _____ Date: _____

Printed Name and Relationship to patient if signed by other (parent, legal guardian, etc.): _____



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www.fmcenter.net

210 N Main Street
Brownstown, IN 47220
Phone: (812) 358-4020
Fax: (812) 358-4449

Patient Name: _____ **Date of Birth:** _____ **SSN:** _____

Acknowledgement of Understanding Privacy Practices

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

I understand that Family Medical Center, P.C. may use and disclose 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 state and federal law may require the release of this information without my permission. These situations are very unusual, such as circumstances where there are concerns of abuse, neglect or violence to you or someone else.

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 patient privacy and is attached to this acknowledgement I understand that I have the right to read the Notice before signing this acknowledgment. Within the Notice of Privacy Practices is contained a complete description of my privacy and confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, account of disclosures as required by law, and requests for communication by specific methods. Family Medical Center, P.C. may update this acknowledgment and Notice of Privacy Practices. If I ask, Family Medical Center, P.C. will provide me with the most current version. 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.

Family Medical Center, P.C. has established procedures to help meet obligations to patients. These procedures may include other signature requirements, authorizations, time frames for requesting information, charges to produce copies or documentation, etc. I agree to 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 medically related messages that may require a return call on my answering machine, voicemail, or text message.

Patient or legally authorized individual signature Date Time

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

Acknowledgement of Appointment Policy

Family Medical Center, P.C. strives to provide timely access to care for all patients. We request that you notify us as soon as possible if you will not be able to make it to your appointment. It is considered a failure of appointment if notice of reschedule or cancellation is not provided 24 hours prior to appointment time. Our failure policy is as follows:

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

Patient or legally authorized individual signature Date Time

Today's Date: _____



PATIENT HEALTH HISTORY

NAME: _____

DOB: _____

MEDICATIONS: include over-the-counter (OTC) medications, vitamins, and supplements

Name	Dose (mg) / #	Frequency/Timing
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

- | | | | |
|-----------------------------------|---------------------|-----------------------------|----------------------|
| ADHD | COPD/ Emphysema | High Cholesterol | Rheumatoid Arthritis |
| Alcoholism | Dementia | HIV | Seizure Disorder |
| Allergies, Seasonal | Depression | Hepatitis | Sleep Apnea |
| Anemia | Diabetes: 1 or 2 | Irritable Bowel Syndrome | Stroke |
| Anxiety | Diverticulitis | Lupus | Thyroid Disorder |
| Arrhythmia (irregular heart beat) | DVT (Blood Clot) | Liver Disease | Ulcerative Colitis |
| Arthritis | GERD (Acid Reflux) | Macular Degeneration | |
| Asthma | Glaucoma | Neuropathy | |
| Bipolar | Heart Disease | Osteopenia/Osteoporosis | |
| Bladder Problems / Incontinence | Heart Attack (MI) | Parkinson's Disease | |
| Bleeding Problems | Hiatal Hernia | Peripheral Vascular Disease | |
| Cancer: _____ | High Blood Pressure | Peptic Ulcer | |
| Headaches | Kidney Stones | Psoriasis | |
| Crohn's Disease | Kidney Disease | Pulmonary Embolism (PE) | |

Last Pap Smear	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date: _____	Normal Polyps
Mammogram	Yes/No Date: _____	Normal Abnormal
DEXA (Bone Density)	Yes/No Date: _____	Normal Abnormal
PSA (Prostate)	Yes/No Date: _____	Normal Abnormal

Other medical problems not listed above:

Surgical History: Please list all prior surgeries and approximate dates performed.

_____	_____
_____	_____



HEALTH HABITS:

Smoking/Vaping/Tobacco Use: Current Past Never Type: _____

Amount/day: _____ # of Years: _____ Year Quit: _____

Alcohol: Current Past Never Type: _____ # Drinks/week: _____ Year Quit: _____

Recreational Drug Use: Current Past Never Type: _____

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

Comments (Please feel free to comment on any answers above): _____

HOSPITALIZATIONS: List Dates, Hospital, and Reason for Hospitalization

IMMUNIZATIONS: All Childhood Immunizations Up To Date Last Tetanus Shot: _____ Pneumonia Shot: _____

FAMILY HISTORY: Please indicate with a check (√) who in your family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, and age

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease	Stroke	Kidney Disease	Cancer Type	Other
Mother									
Father									
Siblings									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Additional Family Information:									

ALLERGIES: Latex No Yes Medications No Yes – List below with reaction: Other: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Eye Doctor, Kidney Doctor, Dentist, etc.):

Patient Signature: _____

Date: _____



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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 the following:

* Doctor or Facility: _____

* Address: _____

* City: _____ * State: _____ * Zip _____

to release the following portions of the medical record of the above named patient. *(check only one option)

- The entire medical record
- The following specific portion of the medical record _____
for the period of _____ to _____.

To: **Family Medical Center, PC**
2026 N Ewing St
Seymour, IN 47274
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Please send via Direct Message HISP (Preferred Choice) or CD.

Direct Message HISP: johnfye@fmcent.allscriptsdirect.net

The medical record is needed for the following purpose:

- Transfer Records From Previous PCP
- Transfer Records From A Specialist
- Transfer Records From A Hospital
- Other: _____

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 ninety (90) 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: _____



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Please rank up to three choices for your primary physician

No Preference

___ *Samuel Borcharding, MD*

___ *Aaron Frey, MD*

___ *John Fye, MD*

___ *Nicholas Lemming, MD*

___ *Bradley Morin, MD*

___ *Martha Shirley, DO*

___ *Pamela Snook-Tidd, MD*

Please list all other family members that are patients at Family Medical Center:

Did someone refer you to our practice? *Yes* *Name:* _____