Patient Registration Form

family medical center
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: ☐ Home ☐ Cell	
Date of Birth:	Sex: ☐ Male ☐ Female	Identify As: ☐ Male ☐ Female	Social Security #:	
Email Address:		Emergency Contact Name:	Relationship to Patient:	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed		Emergency Contact Phone #:		
Employer Name:		Nearest Relative Not Living With You:	Phone #:	
Employer Address:				

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):			Ethnicity (please select one):
☐ White	☐ American Indian or Alaska Native	☐ Asian	☐ Hispanic or Latino
☐ Hispanic	☐ Black or African American	☐ Native Hawaiian or Pacific Islander	☐ Not Hispanic or Latino
☐ Other	☐ Decline		☐ Decline

Preferred Language (please select one): ☐ English ☐ Other ☐ Spanish	Patient's Mother's Name (First, Last):	Patient's Mother's Maiden Name:

Please tell us how you heard about our practice:
☐ Internet/Social Medial ☐ Referral _____ ☐ 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:

We will require a copy of your current insurance card.

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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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 Medial 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

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
Fax: (812) 524-3334

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 or care provider

☐ *No Preference*

___ *Samuel Borcherding, MD*
___ *Aaron Frey, MD*
___ *John Fye, MD*
___ *Nicholas Lemming, MD*
___ *Bradley Morin, MD*
___ *Martha Shirley, DO*
___ *Pamela Snook-Tidd, MD*

____ *Jennifer Guthrie, PA*
____ *Susan Schnitker, NP*
____ *Judy Tape, NP*
____ *Jami VonDielingen, NP*

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

_____

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