Family Medicine Associates of Augusta

1417 Pendleton Road, Augusta GA 30904
706-738-9824 Fax: 706-736-4111

New Patient Registration Form

Full Name: _____ Birth Date: _____

Gender: __M __F Address: _____

SSN: _____ Marital Status: _____

Race: _____ American Indian/ Alaskan Native
_____ Native Hawaiian/ Pacific Islander
_____ Black/ African American
___ Asian
___ White
___ Do not wish to respond

Ethnicity: ___ Hispanic/Latino
___ Not Hispanic/Latino
___ Do not wish to respond

Language: ___ English
___ Spanish
___ Other
If Other, what language: _____

E-mail Address: _____

Phone Number: _____ Cell Number: _____

May we leave a voicemail about appointments, labs, referrals, prescriptions, or any other health care related information? ___ Yes ___ No

Are we allowed to speak with anyone about your healthcare and financial responsibilities? Please list any and all people we may speak with regarding your healthcare. _____

_____

_____

Employer: ___ Yes ___No *School:* ___Yes ___No

Emergency Contact: _____

Phone Number: _____ Relationship: _____

May we speak with this person about your healthcare? ___ Yes ___ No

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Insurance Information

Primary: Insurance Name: _____

Claims Mailing Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID#: _____ Relationship to Patient: _____

Secondary: Insurance Name: _____

Claims Mailing Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID#: _____ Relationship to Patient: _____

FAMILY MEDICINE ASSOCIATES OF AUGUSTA

Current Medical Problems

___ Anxiety ___ Depression ___ Diabetes ___ Heart Problems
___ High Blood Pressure ___ High Cholesterol ___ Lung Problems
___ Thyroid Problems Other: _____
_____

Current and Past Medical Information

Allergies	Dates of Hospitalizations/Surgeries

CURRENT MEDICATIONS

Name	Dosage	Name	Dosage

Preferred Pharmacy and its Location: _____

Patient Name: _____ Date of Birth: _____
Physician: _____ Today's Date: _____

What other healthcare providers or specialists do you see & where are they located?

Previous Primary Care: _____

Cardiologist: _____

ENT: _____

Gastroenterologist: _____

OB/ GYN: _____

Other Providers: _____

Health Maintenance

When was your last…	Date	Location
Colonoscopy		
Pap Smear		
Mammogram		
PSA (Prostate Screen)		
DEXA (Bone Density)		
Eye Exam		
Pneumonia Shot		
Flu Shot		
Shingles Shot		
Tetanus Shot		

FAMILY HISTORY

If you have a family history of any of the below, please list who in the box next to it.

Breast Cancer		Colon Cancer	
High Cholesterol		Prostate Cancer	
Diabetes		Osteoporosis	
Heart Attack		Anxiety/ Depression	
Heart Problems		Psych/Drug/ Alcohol Problem	
Stroke		High Blood Pressure	

SOCIAL HISTORY

Have you ever used tobacco? __ Yes __ No Do you currently use tobacco? __ Yes __ No

If you responded YES to currently using tobacco: How often/how much do you use? _____
__ Cigarettes __ Cigars __ Smokeless Tobacco ___ Are you interested in quitting?

Do you drink alcohol? __ Yes __ No How much/how often? _____

Do you currently exercise? __ Yes __ No What type of exercise? _____

Are you: ___ Single ___ Married ___Divorced ___Separate ___Widowed ___Engaged

Who lives in the home with you? _____

Do you have child(ren)? __ Yes __ No If yes, names and ages? _____

_____

Are you employed? __Yes __No If yes, where? _____

Do you wear your seatbelt while riding in a vehicle? __Yes __No

What are your hobbies: _____

_____

Financial Policy

- Unless other arrangements have been made in advance by either you or your health insurance carrier, payment is due at the time of service. **Co-payments, co-insurance, and deductibles are always due at the time of your visit.**
- We reserve the right to charge you a fee of $30 for administrative visits, including but not limited to the completion of forms relating to pre-employment, school admission or attendance, immunizations, and accident/disability.
- For your convenience, we accept personal checks, cash, debit, and most major credit cards. We may also make payment plan arrangements for patients with larger balances, allowing up to three months of payments. We do have a **returned check fee of $30.00 in addition to the amount of your check**. If your check is returned, our office may elect to no longer accept checks from you and your family. We use the services of an outside collection agency for past due accounts. Accounts in bad debt will be blocked so no further appointments can be made until balance is paid in full.
- **Minors**: All services rendered to minor patients will be the financial responsibility of the adult accompanying the minor.

Insurance Policy

- Our staff will scan your insurance card at check-in. Please have it ready and available for them.
- If your insurance changes or is no longer in effect, you are required to advise our check-in staff.
- We participate with most major carriers and will bill those plans with which we have an agreement. All co-payments, co-insurance, and deductibles are due at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the charge(s).
- If you have insurance coverage through a plan with which we do not have an agreement, we may opt to prepare and send the claim for you as a courtesy; however, payment is still your responsibility at the time of service.
- It is the responsibility of the patient to contact their insurance company if he/she is scheduling a physical to determine whether these services are covered by their insurance company.
- It is the responsibility of the patients to verify if their insurance requires a pre-certification prior to scheduling an appointment with a specialist. Please contact our office to request a pre-cert before scheduling your appointment with a specialist. The pre-certification process requires 72 hours. Some pre-certifications may require an office visit with your physician.

Patient Name: _____ Date of Birth: _____
Physician: _____ Today's Date: _____

Appointment Policy

- Unless other arrangements have been made in advance by either you or your representative, **you are expected to arrive on time or at least 15 minutes prior to your appointment**. We request your notice if you are running late to your appointment. ***Any patient who is late to their appointment may risk being re-scheduled for another appointment.***
- Appointments should be cancelled/rescheduled at least 24 hours prior to your appointment.
- Patients who do not respect our appointment policy and continue to arrive late for appointments or have a pattern of same-day cancellations may receive a **$30 charge** for their appointment and risk being discharged from our practice. **No-shows will be charged a $30 fee** for their missed appointment and may also risk being discharged from our office.

I have read and understand all of the above policies. I agree to be bound by their terms.

_____ _____
Patient/Guardian Signature Date

Notice of Privacy Practices

You may review our Notice of Privacy Practices at any time by visiting our website or requesting a copy from our staff.

By signing below:

- ✓ I acknowledge that a copy of the *Notice of Privacy Practices* for ***Family Medicine Associates*** has been made available to me. I also acknowledge that I have been provided with an opportunity to ask questions regarding the Notice and its contents.

- ✓ I agree that in the event, part of my visit is not covered by my insurance, such as bloodwork or shots; I am responsible for any and all payments not covered.

- ✓ I have reviewed the information above for correctness and have made any and all changes necessary.

- ✓ I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for services.

_____ _____
Patient/Guardian Signature Date

FAMILY MEDICINE ASSOCIATES OF AUGUSTA

Medicare Patients ONLY

I authorize any holder of medical or other information about me or my dependents to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payments of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Patient/Guardian Signature Date