HEALTH NOW
Walk-in Medical Care 631-929-5900

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Birth Date:	Age:	Sex: ☐ M ☐ F	Social Security Number:
Street Address:	Cell phone no.: ( )	Home phone no.: ( )	
P.O. Box:	City:	State:	ZIP Code:
Email:	Race: ☐ Caucasian ☐ African American ☐ Asian		
	Language:	Ethnicity: ☐ Non-Hispanic ☐ Hispanic	
Pharmacy name:	Pharmacy location:	Pharmacy Phone #:	

Referred to the office by: ☐ Family ☐ Friend ☐ Close to home/work ☐ Ad ☐ Internet ☐ Other: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Member ID:	
Insured Name:		
Relationship to Insured:	Insured Date of Birth:	Insured Soc. Sec. No.:
Secondary Insurance:	Member ID:	
Insured Name:		
Relationship to Insured:	Insured Date of Birth:	Insured Soc. Sec. No.:

NEXT OF KIN

Name of local friend or relative:	Relationship to patient:	Preferred phone no.: ( )	
Address of next of kin:	City:	State:	Zip Code:
Mother's maiden name(first and last):			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Medical Home or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

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I, _____ give permission to discuss my medical treatment and all test results to the people listed on this sheet. I understand that whomever I list below will be given any medical information about me. I also understand that I do not have to choose a person to receive my results and have signed below, accordingly.

Name: _____ Phone: _____

Relationship: _____ Phone: _____

Name: _____ Phone: _____

Relationship: _____ Phone: _____

Name: _____ Phone: _____

Relationship: _____ Phone: _____

Name: _____ Phone: _____

Relationship: _____ Phone: _____

____I DO NOT want anyone but me to receive any medical information

Patient Signature: _____ Date :_____

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FINANCIAL POLICY

Thank you for choosing The Medical Home and Dr. Bellamy Brook and his clinicians as your healthcare provider. We are committed to keeping you and your families healthy. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our Financial Policy is important to our professional relationship. Please contact our Practice Administrator if you have any questions at 631-284-3793.

Full payment is due at the time of service. We accept cash, check, and all major credit cards. We reserve the right to charge a $10 monthly billing fee if payment is not made at the time of the service and for any unpaid balances. All patients must complete our "Patient Registration Form" and other related forms. For cases which we bill insurance directly, we must have a copy of the insurance ID card. If payment is not received from the insurance carrier or other responsible third party in 90 days, we have the right to bill you directly. Please notify us immediately of any changes in your insurance or coverage. 24-hour notice is required for copies of medical records and there may be a nominal fee. We also require 72 hours notice for prescription renewals.

We require 24-hour notice if you are unable to keep your appointment. Failure to do so will result in a $50 no-show fee being added to your account. We will gladly waive this fee for emergencies if you reschedule and complete your appointment within 5 business days.

High Deductible Health Plans. Many plans offered on the healthcare exchange and thru employers now carry high deductibles. This means no payment is made by your insurance carrier until your deductible is met. When your services are applied to the deductible we receive no payment for your care. Therefore payment is expected immediately upon receipt of your first billing statement.

Self-Pay... We expect payment at the time of service unless prior arrangements have been made.

HMO/PPO... All co-payments are due at the time of service. We reserve the right to charge a $10 billing fee if payment is not made at the time of service. We are participating in most insurance plans. You are responsible for verifying in or out of network providers for your plan. If you are an HMO member, you will need to change your primary care physician prior to being seen or we will be unable to see you. Your plan may require a referral. Please call at least 72 hours prior to your appointment with the specialist. PPO patients may be responsible for copays, coinsurance and deductibles. Copays paid at the time of service will be deducted from any additional balances.

Workers' Compensation... If you are here as a result of a work-related injury, we will require information regarding both health insurance and your employer's Workers' Compensation insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers' Compensation insurance, you are responsible for any charges incurred. If payment is not received from these third parties within 60 days, we have the right to bill you directly.

No Fault/Accident Claims... If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. If payment is not received from these third parties within 30 days, we have the right to bill you directly.

Medicare... We accept Medicare assignment and as a Medicare patient you are responsible for the 20% coinsurance and deductible. If you have supplemental insurance we will bill it directly for you. We must be notified if you choose a Medicare Advantage Plan for your coverage. Your responsibility is based on the plan you choose.

Holter Monitor Agreement... If I require the use of a bolter monitor, I understand and agree to return the monitor within 24-48 hours of placement of the monitor. I also agree to reimburse the office of Dr. Bellamy Brook $2,500.00 if the monitor is lost or damaged.

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. My information may be shared with outside sources for the purpose of reimbursement and continuity of care. I understand that I am ultimately responsible for payment for all services. Any unpaid balances can be subjected to a $10 per month billing fee in addition to a 1.5% interest charge.

Printed Name of Patient: _____

Signature of Patient or Responsible Party: _____ **Date:** _____

Adult Health History Form

Name: _____Date of Birth: _____Age:_____Today's Date: _____

Your answers on this form will help me better understand your medical history and concerns.

How do you rate your overall health? ☐ *Excellent* ☐ *Good* ☐ *Fair* ☐ *Poor*

Concern: (Rank by priority)	***Onset***	***Frequency***	***Severity***
Example: Headache	*June 2007*	*4x/week*	*mild/mod/severe*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

REVIEW OF SYMPTOMS: *Please check off any symptoms you currently have.*

Constitutional	***Respiratory***	***Skin***	***Cardiovascular***
____*Recent fevers/sweats*	____*Cough/wheeze*	____*Rash*	____*Chest pain*
____*Unexplained weight loss/gain*	____*Coughing blood*	____*Change in a mole*	____*Palpitations*
____*Unexplained fatigue/weakness*	____*Shortness of breath*	____*Dry skin*	____*Leg swelling*
Eyes/Ears/Nose/Throat	***Gastrointestinal***	***Neurological***	***Breast***
____*Change in vision*	____*Heartburn/reflux*	____*Headache*	____*Breast lump*
____*Change in hearing*	____*Blood in stool*	____*Memory loss*	____*Discharge*
____*Allergies/congestion*	____*Nausea/vomiting*	____*Dizziness/Fainting*	
____*Dry mouth*	____*Abdominal pain*		
Genitourinary	***Psychiatric***	***Blood/Lymphatic***	***Musculoskeletal***
____*Painful/bloody urination*	____*Anxiety/stress*	____*Easy bruising*	____*Muscle pain*
____*Sexual concerns*	____*Sleep problems*	____*Unexplained lumps*	____*Joint pain*
____*Leaking urine*	____*Depression*	____*Excess bleeding*	____*Back pain*
____*Vaginal/penile discharge*	____*Suicidal thoughts*		

MEDICATIONS: *Prescription, over-the-counter, herbal products, supplements, recreational drugs, etc.*

Name of Drug	***Strength***	***x per day***	***Why do you take it***	***Who Prescribed it***

ALLERGIES/ REACTIONS TO MEDICATIONS: *Please list or circle:* ***NO KNOWN ALLERGIES***

Medication	***Allergy, Reaction or Side Effect***

SURGICAL/TRAUMA HISTORY: *Please list any surgical procedures or traumas with dates.*

Surgery	Date(year)	Trauma/Injury	Date(year)

PERSONAL & FAMILY HISTORY: *Please check for personal history & indicate family members.*

Condition	Self	Condition	Self	Condition	Self
AIDS		*Ear Problems*		*Neuropathy*	
Alcoholism		*Epilepsy*		*Nicotine Dependence*	
Allergies		*Eye Problems*		*Osteoporosis*	
Anemia		*Fainting*		*Phlebitis*	
Angina		*Genetic Disease*		*Psychiatric Care*	
Arthritis		*Glaucoma*		*Radiation Treatment*	
Artificial Heart Valves		*Headaches*		*Rash*	
Asthma		*Heart Attack*		*Respiratory Disease*	
Back Problems		*Heart Disease*		*Rheumatic Fever*	
Birth Defects		*High Blood Pressure*		*Rheumatoid Arthritis*	
Bleeding Disorder		*High Cholesterol*		*Shortness of Breath*	
Cancer		*Hepatitis or Jaundice*		*Sinus Problems*	
Type:		*Kidney Problems*		*Stroke*	
Chemical Dependency		*Leukemia/Lymphoma*		*Swollen Neck Glands*	
Chest Pain		*Liver Disease*		*Thyroid Disease*	
Chronic Diarrhea		*Low Blood Pressure*		*Tuberculosis*	
Circulatory Problems		*Lupus*		*Ulcers*	
Depression		*Mental Retardation*		*Venereal Disease*	
Diabetes		*Migraines*		*Other:*	

Any family history of these conditions? _____

PODIATRY HISTORY: *What is the chief concern for your visit?* _____

When did you notice the problem? _____ *Other concerns:* _____

Have you been to a Podiatrist before? ☐ *Yes* ☐ *No If yes, please explain:* _____

Is there any personal or family history of diabetes? ☐ *Yes* ☐ *No If so, whom?*_____

Daily activities: _____

Please check off which foot problem you now have or had:

Condition	Self	Condition	Self	Condition	Self	Condition	Self
Ankle Pain		*Cramps or Numbness*		*Heel Pain*		*Tired Feet*	
Arch Problems		*Corns/Calluses*		*Ingrown Toenails*		*Varicose Veins*	
Arthritis		*Foot or Leg Cramps*		*Plantar Warts*		*Other:*	
Athlete's Foot		*Gout*		*Swelling*			

SOCIAL HISTORY: *Please enter the appropriate answer.*

	Type	# Per Day	# Years	Quit Date	Do you want to quit?
Tobacco					Yes No
Alcohol					Yes No
Drugs					Yes No
Caffeine					Yes No

PERSONAL BACKGROUND: *Family Physician:_____ Last Visit Date: _____*
Are you now, or have been, under any doctor's care for any reason in the last two years? ☐ *Yes* ☐ *No*

Weight:
Are you happy with your weight? ☐ *Yes* ☐ *No* *How is your appetite?_____*

Exercise:
Do you exercise regularly? ☐ *Yes* ☐ *No* *What kind of exercise?_____*

Safety:
Do you consistently wear a bike helmet? ☐ *Yes* ☐ *No*
Do you consistently wear sunscreen? ☐ *Yes* ☐ *No*
Do you consistently wear a seatbelt? ☐ *Yes* ☐ *No*
Is violence a concern for you? ☐ *Yes* ☐ *No*
Have you been abused/threatened? ☐ *Yes* ☐ *No*
Do you have a gun in your home? ☐ *Yes* ☐ *No*

Sexual Activity:
Are you sexually active? ☐ *Yes* ☐ *No* ☐ *In the past but not currently*
Do you use birth control? ☐ *Yes* ☐ *No* ☐ *Birth Control Method: _____*
Have you been tested/treated for STDs? ☐ *Yes* ☐ *No*
Your sexual partners are: ☐ *Male* ☐ *Female* ☐ *Both*

Socioeconomics: .
Marital Status: ☐ *Single* ☐ *Partner/Married* ☐ *Divorced* ☐ *Widowed* ☐ *Engaged*
Spouse/Partner's Name: _____
Sex & Ages of Children: _____
Occupation & Employer: _____
Highest Degree of Education:_____
Religious Affiliation: _____
What are the major stressors in your life?_____
What do you do to relax? _____
What are your hobbies/interests? _____

IMMUNIZATIONS: *Please list the dates of your last vaccinations.*

Vaccine	Date (year)	Adverse Reaction?
Influenza *(yearly in certain groups)*		
Pneumonia *(once after age 65)*		
Tetanus *(every 10 years)*		
Other		

WOMEN'S HEALTH:

# Pregnancies:	*# Deliveries:*	*# Abortions/Miscarriages:*
Last Menstrual Period:	*Age at 1st Period:*	*Age at Final Period:*

HEALTH CARE MAINTENANCE: *Please list the dates and results of your last screening tests.*

	Screening Test	***Age***	***Date (year)***	***Results (normal/abnormal)***	
Everyone	*Abdominal Aneurysm*	*60*			*N/A*
	Bone Density(DEXA)	*60*			*N/A*
	Colonoscopy	*50*			*N/A*
	Nerve Conduction Velocity Test				*N/A*
	Peripheral Arterial Disease Test				*N/A*
	Ankle Brachial Index				*N/A*
	Chronic Venous Insufficiency				*N/A*
	Comprehensive Diabetic Foot Exam				*N/A*
Women	*Mammography*	*40*			*N/A*
	Pap Smear/Pelvic Exam	*21*			*N/A*
Men	*Rectal Exam*	*40*			*N/A*
	PSA	*40*			*N/A*

Note*: Screening guidelines are based on an individual's risk factors. The above ages are recommended for a person without increased risk. We may always screen earlier than recommended.*

PHARMACY:

Name: _____Town: _____Phone Number: _____

EMERGENCY CONTACT:

Name:_____Relationship:_____Phone Number:_____

ADVANCED DIRECTIVES:

Have you signed a Do Not Resuscitate Order? ☐ *Yes* ☐ *No*

Have you created a living will or durable power of attorney for health care? ☐ *Yes* ☐ *No*

Proxy's Name: _____ ***Telephone:*** _____

PAYMENTS: *Patients are responsible for all fees including missed visits and returned checks. Interest and late fees may apply on past due balances. Payment is expected at the time services are rendered. Payments exceptions must be arranged before treatment.*

I hereby consent and give my permission to the Dr. Brook & Dr. Nicholas (and the doctor's assistants or designated replacement) to provide the medical/and or podiatric services and medicines, submit my insurance form, consider my signature "on file" for payment, and to release any & all records needed. I understand the privacy policy, and have read and understand the above and agree to be personally responsible for all charges & fees.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Medical Home/Health Now/Lite Step Podiatry or insurance company to release any information required to process my claims.

_____ _____ _____

Signature: *Print Name:* *Date:*

The above history has been reviewed with the patient _____

☐ ***Dr. Bellamy Brook*** ☐ ***Dr. Patricia Nicholas*** ☐ ***Michael Fullam*** ☐ ***Janet Slawinski***

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