PATIENT REGISTRATION

Date _____

Patient Name _____ SS # _____

Street Address _____ Birth Date _____

City/State _____ Zip _____ Tel. # _____

Cell Phone # _____

Patient's Employer _____ Tel. # _____

Employer Address _____ Zip _____

Patient's Email _____

Family Physician _____

Referred By: _____

INSURED PERSON

Insured Person _____ SS # _____ D.O.B. _____

Street Address _____ Tel. # _____ Zip _____

Insured Employer _____ Tel. # _____ Zip _____

Person Responsible For Payment _____

Address _____ Tel. # _____

INSURANCE INFORMATION

#1 I.D. # _____

Primary Insurance Co. _____ Group # _____

Address _____ Phone # _____

#2 I.D. # _____

Secondary Insurance Co. _____ Group # _____

Address _____ Phone # _____

Medicare # _____ Medicaid # _____

Please Sign Here _____

IN ORDER TO CONTROL OUR COSTS OF BILLING, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME SERVICE IS RENDERED.

Patient's Name:_____ Date:_____

MEDICATIONS (Please include mg and how often a day)

1._____ 3._____ 5._____

2._____ 4._____ 6._____

ALLERGIES (Aspirin, sulfa drugs, Penicillin, Iodine, Novocain, latex, foods, etc.)

1._____ 3._____ 5._____

2._____ 4._____ 6._____

SURGERIES

1._____ 3._____

2._____ 4._____

SOCIAL HISTORY

Alcohol ☐ Y ☐ N Tobacco ☐ Y ☐ N

MEDICAL HISTORY

Height_____ Weight_____

Sleep Apnea ☐Y ☐ N Mild☐ Moderate☐ Severe ☐ CPAP ☐ Y ☐N BIPAP ☐ Y ☐N

Diabetes ☐ Y ☐N ☐Type 1 ☐Type 2

Pneumococcal Vaccination ☐ Y ☐ N

Influenza Immunization ☐ Y ☐ N Date:_____ Facility:_____

Hepatitis ☐Y ☐ N ☐ A ☐ B ☐ C

Have you had Colon Cancer: ☐ Y ☐N

**Applies to age 50-74 years*

Have you had a Colonoscopy: ☐Y ☐N Have you had Sigmoidoscopy: Y☐ N☐

FEMALES: Have you had a hysterectomy or tubal ligation: ☐ Y ☐ N

Name of Pharmacy: _____

Address: _____ Phone: _____

FAMILY HISTORY

	Mother	Father	Sister	Brother	Daughter	Son
Breast Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐		☐		☐	
Prostate Cancer		☐		☐		☐
Skin Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Testicular Cancer		☐		☐		☐
Thyroid Cancer	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐		☐		☐	

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes - Type I/Type II	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will file with your insurance company for services rendered. Payment for services not included in your copay are due at the time services are rendered unless payment arrangements have been made. We accept cash, checks, MasterCard, Visa or Discover.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "R&C" which is defined as reasonable and customary by most companies.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Signature _____ Date _____

STEPHEN V. DAY & ASSOCIATES, LTD, LLP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Acknowledge that I was provided a copy of the Notice of Privacy Practices that I have read (or had the opportunity to read if I so chose) and understood the notice.

PATIENT NAME (PLEASE PRINT) _____ **DATE** _____

PARENT OR AUTH. REPRESENTATIVE _____

SIGNATURE _____