ANTOINETTE PATTERSON, M.D., P.C.
3790 OLD US HWY 41N, SUITE A.
VALDOSTA, GA 31602
229-333-0245

REGISTRATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's last name: First: M:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:	Home phone no.: ( )			
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:		Employer phone no.: ( )			
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.	❑ Insurance Plan	❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.: ( )		
Occupation:	Employer:	Employer address:		Employer phone no.: ( )		
Please indicate primary insurance	❑ BCBS	❑ UMR	❑ AETNA	❑ UHC	❑ TRICARE	
❑ MEDICARE	❑ CIGNA	❑ MAIL HANDLER	❑ Other			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
PATIENT/GUARDAIN SIGNATURE				*DATE: / /*		

(Please Print)

NAME:	DATE:

PAST MEDICAL HISTORY

LIST ALL HOPSITALIZATIONS AND SURGERIES:

LIST ALL MEDICATIONS: (MEDICATION NAME, STRENGTH AND HOW OFTEN YOU TAKE THEM)

DO YOU USE ANY TOBACCO PRODUCTS? (SMOKE, DIP OR CHEWING TOBACCO)
IF YES, HOW MUCH AND HOW OFTEN?

DO YOU DRINK ALCOHOL? (YES OR NO) IF YES, HOW MUCH AND HOW OFTEN?

DO YOU DRINK COFFEE? (YES OR NO) IF YES, HOW MUCH AND HOW OFTEN?

****ARE YOU ALLEGERIC TO ANYTHING?****
(PLEASE LIST)

DO YOU HAVE ANY OF THE FOLLOWING? (PLEASE CIRCLE)

RECENT WEIGHT LOOS OR GAIN, CHRONIC FATIGUE, CANCE, HEART DISEASE/MURMUR, HIGH BLOOD PRESSURE, THROMBOPHLEBITIS/BLOOD CLOTS IN THE LUNGS OR VEINS, STROKE, MIGRAINE HEADACHES (DIAGNOSED BY DOCTOR), SEIZURE/EPILEPSY, NUMBNESS, STOMACH/BOWEL PROBLEMS, LIVER DISEASE, HEPTITIS, GALLBALADDER DISEASE, DIABETES/DIABETES IN PREGNANCY, THYROIDS PROBLEMS, ASTHMAS, ANEMIA, BLOOD DISORDERS, BLADDER/URINARY/KIDNEY PROBLEMS, ABNORMAL PAP SMEAR, SEXUALLY TRANSMITTED DISEASE, BREAST PROBLEMS, ABNORMAL OSA, ARTHRITIS/BROKEN BONES/FRACTURE, GLAUCOMA, EYE GLASSES/CONTACTS, ANIEXTY, DEPRESSION, MOOD SWINGS, TROUBLE SLEEPING, OTHER?

(Please Print)

NAME:	DATE:

FAMILY HISTORY:

HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING? PLEASE INDICATE SELF (A), FATHER (F), MOTHER (M), BROTHER (B), SISTER (S).:

HIGH BLOOD PRESURE: _____ DIABETES:_____ HEART DISEASE_____

STROKE: _____ CANCER: _____ OTHER: _____

LIST ANY OTHER FAMILY HISTORY IF NOT LISTED:

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT

PATIENT SIGNATURE: _____ **DATE:** _____

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(Please Print)

NAME:	DATE:

PAYMENT IS DUE FOR ALL OFFICE CHARGES ON THE DAY OF THE EXAMINATION:

REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR PERSONAL INSURANCE BENEFITS BE MADE ON MY BEHALF TO ANTOINETTE PATTERSON, M.D., P.C. FOR ANY SERVICES FURNISHED TO ME. OUR OFFICE DOES NOT ACCEPT ANY FORM OF MEDICAID AS A PRIMARY INSURANCE. I AUTHORIZE ANY OF MY MEDICAL INFORMATION TO BE RELEASED TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR ANY OTHER PARTY OR INSURANCE CARRIER ENTITLED TO INFORMATION REGARDING MY ILLNESS, ACCIDENT OR TREATMENT. ANY ACCOUNT CREDIT OR PATIENT OVER PAYMENT WILL BE CREDITED TO FUTURE VISITS OR SERVICES. I ALSO UNDERSTAND THAT I WILL BE REPSONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CONTRACT AS WELL AS ALL FEES INCURRED IF MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY.

SIGNATURE OF PATIENT OR GUARDIAN

DATE:

ANTOINETTE PATTERSON, M.D., P.C.

NOTICE AND ACKNOWLEDGEMENT

(ACKNOWLEDGEMENT OF PRIVACY PRACTICE)

I ACKNOWLEDGE THAT I HAVE REVIEWED THE POSTED NOTICE OF PRIVACY PRACTICES OBSERVED BY DR. ANTOINETTE PATTERSON M.D., P.C.

SIGNATURE: _____ DATE: _____

(PATIENT/PERSONAL REPRESENTATIVE)

IF PERSONAL REPRESENTATIVE'S SIGNATURE APPEARS, PLEASE DESCRIBE RELATIONSHIP TO THE PATIENT.

_____

_____