OLD TOWNE MEDICAL

9066 HIGHLAND STREET • OLIVE BRANCH, MS 38654 • (662) 874-6164

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.	Date of Birth:
Mailing Address:			
City/State/Zip:			
Sex: ☐ Male ☐ Female	Social Security #:		Marital Status:

Race (please select one):
☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other
☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Home Phone:	Cell Phone:	Work Phone:
Email:	Employer Name & Contact Info:	
Emergency Contact Name:	Emergency Contact #:	Relationship to Patient:

Insurance Information

Primary Policy Holder Information (PROVIDE COPY OF INSURANCE CARD OR FILL IN BELOW):

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Insurance ID #: Group #:	Insurance ID #: Group #:
Policy Holder Name: Policy Holder DOB:	Policy Holder Name: Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Claims Address:	Claims Address:

Responsible Party

Person Responsible for Fees (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Patient Consent

Authorization to provide treatment, insurance assignment and consent to release protected health information (PHI)

I authorize Old Towne Medical, or any medical provider authorized by it, to provide medical services, as may be determined by the medical provider to be in my best interest (or of my dependent if I am signing as a parent or guardian). Further, I hereby assign, transfer and set over to Old Towne Medical all of my rights, title and interest to my medical reimbursement benefits under my insurance policy or any other third party payor that may be responsible for paying me for these services. Should payments be made directly to me, I agree to immediately endorse such payment to Old Towne Medical.

I consent to the release of my Protected Health Information for the purpose of treatment, payment and health operation. This is in compliance with our Privacy policy. You have the right to review the privacy notice prior to signing this consent. We reserve the right to change our privacy practices and these changes will be reflected in an updated privacy notice. You can obtain a copy of our most recent notice from our receptionist or office manager.

I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Old Towne Medical all money to which I am entitled for medical reimbursement related to the services performed. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I agree to pay all collection costs including, but not limited to, bad check charges, court costs, witness expenses and reasonable attorney fees if it becomes necessary to turn this account over to an outside party for collections.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare and Medi-gap benefits be made to Old Towne Medical. I authorize any holder of medical information about me to release to my insurer any information needed to determine these benefits.

I have reviewed a copy of Old Towne Medical's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ Date_____

Printed Name of Responsible Party:_____

Old Towne Medical

9066 Highland Street Olive Branch, MS 38654

MEDICAL HISTORY

In an effort to serve you better, please fill out the form below. All information is held strictly confidential and is released only with your written consent.

Name: _____ **DOB:** _____ **Date**: _____

Your main symptoms for today's visit: _____

Pharmacy: _____

Allergies: Please list type and reaction:

Drug	Reaction	Drug	Reaction

Medications: Please list all prescription medications or provide medicine bottles:
Old Towne Medical DOES NOT prescribe chronic narcotic pain medications or Xanax (Alprazolam); May discuss alternatives with the Provider.

Drug	Dosage/Frequency	Drug	Dosage/Frequency

Vaccines: Please check mark if you have had the following vaccines and when:

	Vaccine:	Date:		Vaccine	Date:
	Flu Vaccine			Pneumonia Vaccine	
	Tetanus Vaccine			Hepatitis Vaccine	
	Shingles Vaccine			Human Papillomavirus	

Family History: Please check mark if your parents, brothers, sisters or children had any of the following and write in their relationship to you. **Also please indicate if they are alive or deceased.**

	Breast Cancer		Colon Cancer
	Diabetes		Ovarian Cancer
	Heart Disease		Other Diseases:

Do you use tobacco?	**Have you ever used tobacco?**
○ Yes	○ Yes
○ No	○ No
Number of years:	Quit Date:

Do you drink alcohol?	**If so, please check mark all that apply:**
○ Yes	○ Beer
○ No	○ Wine
Number of years:	○ Liquor

Surgical History: List names and dates of all operations you have had:

Name of Operation	Year	List any complications

Illness/Injury: Please check mark if you have had any of the following conditions:

Anemia		Anxiety		Arthritis		Artery Disease	
Enlarged Prostate		Back Problems		Breast Cancer		High Cholesterol	
Congestive Heart		COPD		Cancer		Diabetes	
Dementia		Depression		Dermatitis		Gout	
Epilepsy		Gastric Reflux		Glaucoma		Hypertension	
HIV		Headaches		Hepatitis		Kidney Stones	
Heart Attack		Migraines		Thyroid Disease		Ulcers	
Stroke		Tuberculosis		Asthma		Other	

Tests: Please check mark if you have had the following tests and when:

	Test Performed	Date	Location
	Mammogram		
	Pap Smear		
	Treadmill/Stress Test		
	Cardiac Catheter (Dye test on heart)		
	Echocardiogram		
	Colonoscopy		
	EGD (Tube camera going through the mouth)		

Please list all other Specialists (Doctors) you are seeing now on a regular basis:

Doctors Name	Specialty

We honor the confidentiality of your medical records and will not share the contents of these records with family or friends without your permission. Please list names below to whom we can release your medical information to:

Medical Records Confidentiality

Name	Relationship	Phone Number

****ALL LAB RESULTS WILL BE SENT BY DEFAULT TO THE PATIENT PORTAL – PLEASE DISCUSS WITH FRONT DESK IF YOU DO NOT HAVE A PORTAL ACCOUNT****

The above information is true and accurate.

Patient Signature: _____ Date: _____

Patient Name: _____**Date of Birth:** _____

Address: _____

Date and Location of last Mammogram:_____

I REQUEST AND AUTHORIZE THE RELEASE OF MY MOST RECENT MAMMOGRAM

FROM (Name of physician or facility with original records)

Name _____
Address _____
City/State/Zip _____
Phone _____
Fax _____

TO OLD TOWNE MEDICAL 9066 Highland St Olive Branch, MS 38654, Phone:662-874-6164/Fax 662-874-6038

Date and Location of last Colonoscopy: _____

I REQUEST AND AUTHORIZE THE RELEASE OF MY MOST RECENT COLONOSCOPY

FROM (Name of physician or facility with original records)

Name _____
Address _____
City/State/Zip _____
Phone _____
Fax _____

TO OLD TOWNE MEDICAL 9066 Highland St Olive Branch, MS 38654, Phone:662-874-6164/Fax 662-874-6038

If you are a Diabetic, Date and Location of last Diabetic Eye Exam: _____

I REQUEST AND AUTHORIZE THE RELEASE OF MY MOST RECENT DIABETIC EYE EXAM

FROM (Name of physician or facility with original records)

Name _____
Address _____
City/State/Zip _____
Phone _____
Fax _____

TO OLD TOWNE MEDICAL 9066 Highland St Olive Branch, MS 38654, Phone:662-874-6164/Fax 662-874-6038

☐ **I do not want to provide the above requested information.**

I understand that I may revoke this consent at any time except that action has been taken in reliance thereon. I hereby release and forever discharge the releasing facility, its employees, officers and agents from liability arising out of release of my medical records as specified above and pursuant to this signed authorization. I accept responsibility for any fees incurred for production of records.

Patient Signature: _____ **Date:** _____

Signature of Legal Guardian: _____