

# PATIENT REGISTRATION FORM

\*\*Today's Date: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

## PATIENT INFORMATION: (Please use full legal name, no nicknames)

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
\*Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_  
\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Drivers Lic#: \_\_\_\_\_  
\*Employer Name and Address: \_\_\_\_\_  
Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Emerg Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please tell us how you heard about us: \_\_\_\_\_ Referred by \_\_\_\_\_

## GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

\*Relationship of Guarantor to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_  
\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
\*Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ \*Social Security #: \_\_\_\_\_  
\*Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ \*Sex: Female \_\_\_\_\_ Male \_\_\_\_\_  
\*Employer Name and Address: \_\_\_\_\_  
Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

*IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*

### PRIMARY INSURANCE:

Plan Name: \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_  
Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_  
\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ Eff Date: \_\_\_\_\_  
Claims Address & Phone: \_\_\_\_\_

### SECONDARY INSURANCE:

Plan Name: \_\_\_\_\_ \*Insured's Name: \_\_\_\_\_  
\*Insured's Social Security #: \_\_\_\_\_ \*Insured's Date of Birth: \_\_\_\_\_  
\*Policy / ID #: \_\_\_\_\_ \*Group #: \_\_\_\_\_ \* Eff Date: \_\_\_\_\_  
Claims Address & Phone: \_\_\_\_\_

\*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. \*ATTACH COPY OF INSURANCE CARDS.

*Please read and sign back of form.*



## Medical History

1. Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Chart Number \_\_\_\_\_

2. Do you use tobacco products? Yes  No   
What type and how much per day? \_\_\_\_\_

3. Do you drink alcoholic beverages? Yes  No   
What type and how much per day? \_\_\_\_\_

4. Do you use drugs? Yes  No   
What type and how much per day? \_\_\_\_\_

5. Date of last: Pneumovax \_\_\_\_\_ T B Skin Test \_\_\_\_\_  
Cholesterol \_\_\_\_\_ Eye Exam \_\_\_\_\_  
Tetanus Shot \_\_\_\_\_ Results \_\_\_\_\_

Women: Date of last menstrual period \_\_\_\_\_ Pap Smear \_\_\_\_\_  
Mammogram (Diagnostic or Screening) \_\_\_\_\_  
Where at? \_\_\_\_\_

6. Past Hospitalization / Surgery / Fractures (list date and reasons):

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_: \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_: \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_: \_\_\_\_\_

7. Personal and family history: Please check if your or a blood-related member of your family has or have any of the following. Please include who and what type of problem.

A. Heart Attack	<input type="checkbox"/>	_____	K. Cancer (What kind)	<input type="checkbox"/>	_____
B. High Blood Pressure	<input checked="" type="checkbox"/>	_____	L. Mental Illness	<input type="checkbox"/>	_____
C. Stroke	<input type="checkbox"/>	_____	M. Glaucoma	<input type="checkbox"/>	_____
D. Lung Problems	<input type="checkbox"/>	_____	N. Kidney Disease	<input type="checkbox"/>	_____
E. Asthma	<input type="checkbox"/>	_____	O. Thyroid Disease	<input checked="" type="checkbox"/>	_____
F. Alcoholism	<input type="checkbox"/>	_____	P. Rheumatic Fever	<input type="checkbox"/>	_____
G. Diabetes	<input type="checkbox"/>	_____	Q. Lung Disease	<input type="checkbox"/>	_____
H. TB	<input type="checkbox"/>	_____	R. Seizure	<input type="checkbox"/>	_____
I. Anemia	<input type="checkbox"/>	_____			
J. Arthritis	<input type="checkbox"/>	_____			

8. Other things about your health you wish the doctor to know:

9. List any chronic diseases you may have:

**Family Wellness Clinic**  
**105 S Ellington St**  
**Clayton, NC 27520**  
**(919)553-5711**  
**(919)553-5712**

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

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Family Wellness reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

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Name of Patient (Print)

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Signature of Patient

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Date of Patient Signature

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Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient

Please place in the patient's medical record.

**Dr. Bhavna Vaidya-Tank**  
105 South Ellington Street  
Clayton, NC 27520  
919-553-5711  
Fax 919-553-5712

Date \_\_\_\_\_

I authorize Dr. Bhavna Vaidya-Tank's personnel to leave confidential healthcare information including test results at any of the following:

\_\_\_\_\_ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my home answering machine.

\_\_\_\_\_ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left on my work voice mail.

\_\_\_\_\_ I authorize that any healthcare (including lab reports, test results, etc.) and/or billing related information may be left with:

Full name of person: \_\_\_\_\_

\_\_\_\_\_ I do not authorize any healthcare or billing related information being released in any of the above fashions. Such information should only release to me personally.

I authorize the person listed below to pick up prescriptions, samples, forms and medical records.

Full name of person: \_\_\_\_\_

Note: photo ID will be required

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

## Family Wellness Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

**8. Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date