Kettering Family Practice
Patient Registration Information

NAME (Last, First, MI): DATE:

SEX: M F RACE: ETHNICITY: Hispanic / Latino Y / N BIRTH-DATE: / / AGE S.S. NO.: – – MARITAL STATUS:

ADDRESS:

CITY: STATE: ZIP: EMAIL:

HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )

EMPLOYER: EMPLOYER PHONE:

ADDRESS:

CITY: STATE: ZIP:

SPOUSE NAME: SPOUSE S.S. NO.: — —

SPOUSE EMPLOYER: EMPLOYER PHONE:

NAME AND TELEPHONE # OF EMERGENCY CONTACT:

PREFERRED PHARMACY: ADDRESS: PHONE:

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS:

NAME: RELATIONSHIP TO PATIENT:

ADDRESS:

CITY: STATE: ZIP:

S.S. NO.: PHONE NO: ( )

EMPLOYER: EMPLOYER PHONE:

ADDRESS:

IF MINOR: MOTHER'S NAME: FATHERS NAME:

INSURANCE INFORMATION
(Please present your insurance card to the receptionist)

PRIMARY INSURANCE

INSURANCE CO.

CITY STATE

ID # GROUP/PLAN#

EFFECTIVE DATE RELATION TO PATIENT

INSURED'S NAME DOB

SS#

INSURED'S EMPLOYER

ADDRESS

SECONDARY INSURANCE

INSURANCE CO.

CITY STATE

ID # GROUP/PLAN#

EFFECTIVE DATE RELATION TO PATIENT

INSURED'S NAME DOB

SS#

INSURED'S EMPLOYER

ADDRESS

CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF BILLING INFORMATION

I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Kettering Family Practice for insurance claim submission and/or payment for services. I authorize payment of medical benefits to Kettering Family Practice for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for the services rendered.

DATE: / /	SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR): X	RELATION TO PATIENT:

Kettering Family Practice

Today's Date:_____

MEDICAL HISTORY

Please Print

BP:_____ Ht.:_____ Wt:_____

Patient Name:_____ D.O.B._____ Sex:_____

HEALTH HISTORY OF THE PATIENT

	Yes	No
Anesthesia Problems		
Asthma		
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Acid Reflux		
Nasal Allergies		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
HIV/AIDS		
Liver Trouble		
Thyroid Trouble		
Stomach Ulcer		
Sleep Apnea		
Other Illnesses		

Explain all Yes answers

_____

_____

_____

List all Surgeries (include approx. date:):

_____

_____

_____

_____

Current Medications and Dosage:

_____

_____

_____

Allergies to Medicine: (None ☐)

_____

_____

FAMILY HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Anesthesia Problems		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		

Explain all Yes answers

_____

_____

_____

Cause of death of parents, or brothers or sisters

_____

_____

_____

_____

_____

REVIEW OF SYMPTOMS

Have you recently had or do you now have:

	Yes	No
Chills or Fever		
Night Sweats		
Recent Weight Change		
Poor Appetite		
Fatigue		
Reading Glasses		
Changes in Vision		
Eyes Sensitive to Light		
Watery/Itchy Eyes		
Hearing Loss		
Ringing/Buzzing in Ears		
Ear Pain		
Nasal Congestion		
Nosebleeds		
Sinus Pressure		
Dry Mouth		
Gum Trouble		
Toothache		

REVIEW OF SYMPTOMS CONTINUED

Have you recently had or do you now have:

	Yes	No
Persistent Snoring		
Hoarseness		
Difficulty Swallowing		
Chest Pain/Discomfort		
Abnormal Heartbeat		
Shortness of Breath		
Calf Cramps While Walking		
Ankle Swelling		
Cough		
Wheezing		
Pain on Breathing		
Coughing Blood		
Heartburn		
Nausea/Vomiting		
Stomach Pain		
Frequent Belching		
Frequent Loose Bowel Movement		
Frequent Constipation		
Blood in Bowel Movements		
Hemorrhoids		
Frequent Urination		
Burning on Urination		
Blood in Urine		
Difficulty Starting Urination		
Getting up Every Night to Urinate		
Flank Pain		
Joint Aches		
Muscle Aches		
Swollen Glands		
Bleeding Problems		
Easy Bruisability		
Hair Loss		
Constantly Thirsty		
Constantly Hungry		
Hot or Cold Spells		
Rashes		
Hives		
Hair Changes		
Frequent Headaches		
Seizures		
Blackouts		
Tremors		
Numbness		
Tingling		
Insomnia		
Anxiety/Panic		
Depression		
Women Only		
Are you Pregnant?		
Are You Nursing?		

SOCIAL HISTORY

Smoke_____ packs/day for _____years

Alcohol: Never ☐ Occasional ☐

Moderate to Heavy ☐

Drug Overuse: ☐ None ☐

Presently ☐ Past Problem ☐

Most Recent Occupation: _____

_____

Married ☐ Single ☐ Divorced ☐

Number of Children Living

Number of Pregnancies

Presently Living Alone? Yes ☐ No ☐

KETTERING
FAMILY PRACTICE

FINANCIAL POLICY

In order for us to deliver quality care, we have established our financial policies.

PLEASE READ ALL INFORMATION AND SIGN BELOW.

1. We may ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. If you have a change of address, phone number, or employer, please notify the receptionist and we will give you a form to update.
   ***INITIALS** _____

2. We will collect your deductible, copay, charges for non-covered services and any **outstanding balance AT THE TIME OF YOUR VISIT**. *NO EXCEPTIONS* Patients with no insurance will be expected to pay in full at each visit.
   ***INITIALS** _____

3. We will file your insurance to your plan. You are to make sure payment is made by your insurance company. Your insurance may not cover all your visit. It is the patient's responsibility to know their policy. After you receive a billing statement from us payment is expected **within 30 days**.
   ***INITIALS** _____

4. If your plan requires you to choose a primary care physician, it is your responsibility to make sure our physicians are listed as your PCP. If your plan requires you to have an authorization to see a specialist, or for testing, you will need to obtain that from our office prior to seeing the specialist/facility. It is the patient's responsibility to notify us each time an authorization is needed. No retroactive referrals will be given.
   ***INITIALS** _____

5. When an appointment is scheduled with the doctor/nurse, time is specifically allocated for you. When an appointment is not cancelled in advance, another patient that needed to be seen could have been scheduled. "No show" appointments will be charged a $25.00 fee. Multiple "no show" appointments can lead to dismissal from the practice.
   ***INITIALS** _____

6. Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you ever have any questions concerning your billing, call our billing department at (937) 298-1439.

By signing this document I confirm to have read and that I understand the financial policy of Kettering Family Practice.

SIGNATURE _____ **DATE** _____

KETTERING
FAMILY PRACTICE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

☐ I consent to Kettering Family Practice using and disclosing my protected personal health information to carry out treatment, payment, or health care operations.

☐ I understand and have been provided with a NOTICE OF PRIVACY PRACTICES, which provides a more complete description of how my protected personal health information may be used or disclosed. These can be found in the binders of the lobby.

You have the right to request that we restrict disclosure of your Protected Health Information only to certain individuals involved in your care, such as family members and friends.

☐ I do not wish any information given to anyone.

OR

☐ Information may be shared with only the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

PRINTED PATIENT'S NAME _____

SIGNATURE (PATIENT/LEGAL GUARDIAN) _____

DATE _____

This notice will stay in effect until revoked by the patient.