Johnson Family Medical 469-656-4602 www.johnsonfamilymedical.com

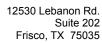




Registration Form

GENERAL INFORMATION				TODAY'S DAT	E:		
Patient's Name:Last Name	First	Name	MI	D.O.B.:			Age:
Address:				_ Phone: ()	-	
City:	_ State:	Zip Code:		_ SSN:			_ Sex: M/F
E-mail:				Marital Status	: M S	D W	Dom. Partner
Emergency Contact:			Relation:	Phone	: ()	
Name of Insurance:			Member ID	:	Grou	ıp ID:	
Preferred Pharmacy:			Pharmad	cy Phone:			
I hereby authorize Johnson Fa text messages), and email to c					including	address,	phone (call or
PERSON RESPONSIBLE FOR	PAYMENT						
Last Name	First Name	ľ	MI	Relationship t	o patient		
Phone: ()							
SSN:		Sex: M /	F D.O.E	3.:		Age: _	
Address:			Employer:				
City:	State:	Zip code: _	Wo	rk Phone:()	- -	
AUTHORIZATION TO RELEAS I request that payment of auth Johnson Family Medical for at these benefits or the benefits understand that even though I note: It is the policy of this off subsequent fees.	orized insurance ny services furnis payable for the re have some type	benefits from shed me by the elated service of insurance	n any applica hat provider. es to be relea coverage, I a	able insurance ca I authorized medi sed to the insura am responsible fo	cal inforn nce comp or the pay	nation nee any and i ment of se	eded to determine ts agents. I ervices. Please
Name:			Signature:				-
Relationship:			Date:				

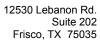
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Name:	DOB: _		Today	's Date:	
	Me	edical History			
AutoImmune Disorder:		Neuro	logical Disor	der:	
□ Alopecia			□ Bell's Pal	sy	
□ Celiac			□ Epilepsy		
□ Hashimotos			□ Fibromya	lgia	
□ Lupus			□ Multiple S	Sclerosis	
□ Rheumatoid Arthritis			□ Parkinsor	า'ร	
□ Sarcoidosis			□ Periphera	ll Neuropathy	
□ Scleroderma			□ Seizure A	ctivity	
□ Sjogren's			□ Stroke		
□ Vasculitis		Naura	mua autar Dia	a red a re	
Cancer or History of Cancer: - Ves -	No	Neuro	muscular Dis		
Cancer or History of Cancer: □ Yes □ □ Chemotherapy / Radiation	INO		□ ALS / Lou	Eaton Syndrome	
□ Lymph Node Removal				/eakness / Tremors	
□ Melanoma or Other Skin Can	cor				
□ Precancerous Skin Lesions	CEI		□ Myasthen		
- Frecancerous Skiri Lesions			□ Ally Neul	omuscular Disorder	
Cardiac Conditions:		Skin C	ondition / Di	sease / Lesions:	
□ Arrhythmia			□ Active Ac	ne	
□ Blood Clotting Abnormalities		□ Actinic Keratosis			
□ Blood Vessel (Vascular) Disea	ase		□ Eczema		
□ Heart Attack			□ Fungal In	fection (Ringworm)	
□ Heart Disease / Failure			□ Impetigo		
□ High Blood Pressure			□ Keloid Sc	arring / Raised Scarring	
□ High Cholesterol			□ Keratosis	Pilaris	
□ Cardiac Procedures:			□ Melasma		
			□ Psoriasis		
			□ Raised M	oles / Warts / Lesions	
			□ Rosacea		
Other Conditions:			□ Vitiligo		
□ Acid Reflux	□ Depress	ion		□ Lymphedema	
□ ADD / ADHD	□ Diabetes	5		□ Nervous Diagnosis	
□ Anemia	□ Digestive	e / GI Problems		□ Osteoporosis	
□ Anxiety	□ Extreme	Fatigue		□ PCOS	
□ Any Active Infection	□ GERD			□ Seasonal Allergies	
(Bacterial / Fungal / Viral)	□ Gout			□ Sexual Dysfunction / ED	
□ Arthritis / Rheumatism	□ Headach	nes / Migraines		□ Shingles Outbreak	
□ Asthma	□ Hearing	/ Vision Issues		□ Thyroid Imbalance/Disease	
□ Cirrhosis	□ Hepatitis	3		□ Ulcer	
□ Cold Sores (HSV 1)		os -		□ Urinary Incontinence	
□ COPD	□ Hormone	e Imbalance		□ Vision Problems	

 $\ \square$ I have reviewed ALL of the above conditions and DO NOT HAVE ANY of those listed or ANY conditions not listed that my provider should be made aware of.





Name:			DOB:	To	oday's Date:		
Allergies Medication or Subst	ergies dication or Substance:		Describe Reaction or Symptoms:				
Ever experienced ar	n anaphyla	actic resp	onse? □ Yes	o □ No			
Current Medication Name of Medication		ng Retin-	A, Accutane,	etc.) Dose / Frequency:			
Herbal, Vitamin or Name of Substance		-	pies (including	g acids in facial wash ր Amount / Frequend	•		
Past Surgical Histo	ory		Date	Colonoscopy Mammogram	□ Yes □ No	_	Date
Social History	ı No Va	 pina: □ Y	 ∕es ⊓ No	PAP Smear	□ Yes □ No	_	
Cigarettes:			Amount / Frequency Amount / Frequency Amount / Frequency Duration / Frequency				
Family History		• • •	0.1.1.				011.11
Deceased? Alcoholism Asthma Bleeding Disorder Cancer	Father	Mother	Siblings	Heart Failure High Blood Pressu Mental Illness Osteoporosis Stroke	Father Ire	Mother □ □ □ □ □ □ □ □ □ □ □	Siblings
Diabetes Heart Disease			_ _ _	Thyroid Disease Other:			



Financial Assignment / Authorization Agreement

Medicare Assignments of benefits to <u>Statement to Permit of Health and/or Medical insurance benefits</u>
To Johnson Family Medical and Providers

I certify that the information given by me in applying for payment under title XVLIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed or for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician and/ or mid level (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and coinsurance.

FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the inability to pay in full at the time service is rendered; Johnson Family Medical may inquire of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5% per month / 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as an attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expenses.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Johnson Family Medical, Frisco, Texas any benefits under hospitalization, sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

I hereby authorize the staff of Johnson Family Medical to administer such care / treatment as it is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment, laboratory, and radiologic test(s). I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Johnson Family Medical to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be released.

Name:	Signature:
Relationship:	Date:



Acknowledgements / Consents

Please Initial		
Receipt of HIPAA Notice of I, (print patient or guardian namedical HIPAA Notice of Privowww.johnsonfamilymedical.com	ame) vacy Practices. (This document is availa	, have read a copy of Johnson Family able at front desk or
within 24-hours of the schedu \$45 fee if the patient does no appointment may need to be	uled appointment. Johnson Family Med ot cancel the appointment within 24-hou rescheduled. After TWO consecutive n s strictly enforced. (The complete Office	tient's responsibility to call the office to cancel ical reserves the right to charge the patient a rs. If you are more than 5 minutes late, your to-shows, the practice may elect to terminate e Policy is available at front desk or
Release of Medical Informa I do / do not (circle one) auth information to the following ir	orize Johnson Family Medical and its d	esignated representatives to release medical
Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:
	□ Leave a detailed voicemail □ significant other (Name:	
□ Speak with spouse / □ Speak with other fam Consent to Treatment Johnson Family Medical has Family Medical is a family me Practitioner (FNP) who also I (RN), also known as Adult No certification in their specialty.	significant other (Name:	n the delivery of primary health care. Johnson by Katherine A.W. Johnson, a Family Nurse SN). A nurse practitioner is a Registered Nurse Masters Degree in Nursing and a board becialty areas such as family practice,
skills and training in the care	of people of all ages, plus the authority and hereby accept the services of a nurse	
purposes. X-rays and ultraso conditions. The Photograph,	 Medical uses photographs of patients bund, if necessary, are used in diagnosis 	s or identification of specific illnesses or distributed outside the medical practice
My signature below indicates that I ha	ave read and agree with all statements	that I have initialed above.
Name:	Signature:	
Relationship:	Date:	