



Registration Form

GENERAL INFORMATION

TODAY'S DATE: _____

Patient's Name: _____ D.O.B.: _____ Age: _____
Last Name First Name MI

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: _____ Group ID: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

I hereby authorize Johnson Family Medical and/ or agents to use my general information, including address, phone (call or text messages), and email to contact me to facilitate anything related to my medical care.

PERSON RESPONSIBLE FOR PAYMENT

Last Name First Name MI Relationship to patient

Phone: (_____)- _____ - _____

SSN: _____ - _____ - _____ Sex: M / F D.O.B.: _____ Age: _____

Address: _____ Employer: _____

City: _____ State: _____ Zip code: _____ Work Phone: (_____) _____ - _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Johnson Family Medical for any services furnished me by that provider. I authorized medical information needed to determine these benefits or the benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.

Name: _____ Signature: _____

Relationship: _____ Date: _____

Name: _____ DOB: _____ Today's Date: _____

Medical History

Auto Immune Disorder:

- Alopecia
- Celiac
- Hashimotos
- Lupus
- Rheumatoid Arthritis
- Sarcoidosis
- Scleroderma
- Sjogren's
- Vasculitis

Cancer or History of Cancer: Yes No

- Chemotherapy / Radiation
- Lymph Node Removal
- Melanoma or Other Skin Cancer
- Precancerous Skin Lesions

Cardiac Conditions:

- Arrhythmia
- Blood Clotting Abnormalities
- Blood Vessel (Vascular) Disease
- Heart Attack
- Heart Disease / Failure
- High Blood Pressure
- High Cholesterol
- Cardiac Procedures: _____

Other Conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervous Diagnosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Digestive / GI Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Extreme Fatigue | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Any Active Infection
(Bacterial / Fungal / Viral) | <input type="checkbox"/> GERD | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Gout | <input type="checkbox"/> Sexual Dysfunction / ED |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Shingles Outbreak |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hearing / Vision Issues | <input type="checkbox"/> Thyroid Imbalance/Disease |
| <input type="checkbox"/> Cold Sores (HSV 1) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Urinary Incontinence |
| | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Vision Problems |

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: _____ Today's Date: _____

Allergies

Medication or Substance:	Describe Reaction or Symptoms:
_____	_____
_____	_____

Ever experienced an anaphylactic response? Yes No

Current Medications (including Retin-A, Accutane, etc.)

Name of Medication:	Dose / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Herbal, Vitamin or Nutritional Therapies (including acids in facial wash products)

Name of Substance / Therapy:	Amount / Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History

Procedure:	Date		
_____	_____	Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	PAP Smear	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Date

Social History

Cigarettes: Yes No Vaping: Yes No Moist Tobacco: Yes No Other: _____
 Amount / Frequency _____

Alcohol: Yes No Type _____ Amount / Frequency _____

Caffeine: Yes No Type _____ Amount / Frequency _____

Recreational Drugs: Yes No Type _____ Amount / Frequency _____

Exercise: Yes No Type _____ Duration / Frequency _____

Diet: Yes No Type _____ Description _____

Family History

	Father	Mother	Siblings		Father	Mother	Siblings
Deceased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Financial Assignment / Authorization Agreement

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

I certify that the information given by me in applying for payment under title XVI 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 midlevel (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 unable to pay in full at the time service is rendered; Johnson Family Medical may inquiry 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 attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expense.

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, and laboratory, and radiologic test. 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 released 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 so released.

Name: _____

Signature: _____

Relationship: _____

Date: _____

Acknowledgements / Consents

Please Initial

Receipt of HIPAA Notice of Privacy Practices

I, (print patient or guardian name) _____, have read a copy of Johnson Family Medical *HIPAA Notice of Privacy Practices*. (This document is available at front desk or www.johnsonfamilymedical.com)

Cancellation Policy

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24-hours of the scheduled appointment. Johnson Family Medical reserves the right to charge the patient a \$45 fee if the patient does not cancel the appointment within 24-hours. If you are more than 10-minutes late, your appointment may need to be rescheduled. After TWO consecutive no-shows, the practice may elect to terminate our relationship. This policy is strictly enforced. (The complete Office Policy is available at front desk or www.johnsonfamilymedical.com)

Release of Medical Information

I do / do not (circle one) authorize Johnson Family Medical and its designated representatives to release medical information to the following individuals:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

Contact Permission

In the event that Johnson Family Medical needs to contact you (patient) regarding appointments, medications, test results, or any other reason, it is permissible to (check all that apply):

- Call / Text Cell phone Leave a detailed voicemail DO NOT leave a detailed voicemail
- Call Home phone Leave a detailed voicemail DO NOT leave a detailed voicemail
- Speak with spouse / significant other (Name: _____)
- Speak with other family members

Consent to Treatment

Johnson Family Medical has an advanced practice nurse to assist in the delivery of primary health care. Johnson Family Medical is a family medical clinic that is owned and operated by Katherine A.W. Johnson, a Family Nurse Practitioner (FNP) who also has a Master of Science in Nursing (MSN). A nurse practitioner is a Registered Nurse (RN), also known as Adult Nurse Practitioners (ANP), has at least a Masters Degree in Nursing and a board certification in their specialty. They have education and training in specialty areas such as family practice, women's health or pediatrics. Family Nurse Practitioners have acquired the necessary knowledge and expertise, skills and training in the care of people of all ages, plus the authority to issue prescriptions for medications. *I have read this document and hereby accept the services of a nurse practitioner for my health care needs.*

Consent for Medical Photos

I understand Johnson Family Medical uses photographs of patients for identification and patient progress purposes. X-rays and ultrasound, if necessary, are used in diagnosis or identification of specific illnesses or conditions. The Photograph, X-Ray & Ultrasound images will not be distributed outside the medical practice unless collaboration with other physicians or practitioners is medically necessary.

My signature below indicates that I have read and agree with all statements that I have initialed above.

Name: _____

Signature: _____

Relationship: _____

Date: _____