Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

Harrisonville Family Medicine, Inc,
Privacy Consent Form

(Check all that apply)

_____ Myself

_____ Spouse: _____

Family Member:

_____ ALL Adult Family Members

_____ ONLY: _____

_____ Parent or Family Member (For Minor Child)

Mother: _____

Father: _____

_____ May leave a detailed message on answering machine / voicemail

_____ NO Details on answering machine / voicemail – Only to call office

_____ Email: _____

_____ Consent to text (i.e. appt reminders, office closure due to weather or holidays, etc.)

_____ Other: _____

Note: It is your responsibility to notify HFM of any changes that need to be made to this form.

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my / my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

_____ _____

Patient / Personal Representative Date

_____ _____

Relationship to Patient Witness

REVISED 11/10/2016

Past Medical History Patient Name: _____

Date: _____ DOB: _____

Past Medical History

Gastrointestinal
Ulcer _____
Colon Polyps _____
Colon Infections _____
Diverticulosis _____
Diverticulitis _____
Acid Reflux _____
Hepatitis _____
Liver Disease _____
Irritable Bowel Disease _____
Crohn's Disease _____

Endocrine
Elevated Thyroid Levels _____
Low Thyroid Levels _____
Diabetes Type I _____
Diabetes Type II _____

Pulmonary
Environmental Allergies _____
Chronic Lung Disease _____
Chronic Bronchitis _____
Chronic Sinusitis _____
Asthma _____
Sleep Apnea _____

Musculoskeletal
Low Back Pain _____
Gout _____
Rheumatoid Arthritis _____
Osteoporosis _____
Osteoarthritis _____
Fibromyalgia _____

Cardiovascular
Coronary Artery Disease _____
Atrial Fibrillation _____
Previous Heart Attack _____
Elevated Blood Pressure _____
High Cholesterol _____
Blood Clot _____
Congestive Heart Failure _____

Genitorinary
Kidney Stones _____
Chronic Kidney Disease _____
Urinary Tract Infections _____

NeuroPsych
Seizure Disorder _____
Stroke _____
Attention Deficit Disorder _____
Depression _____
Anxiety _____
Dementia _____
Alzheimer's _____
Bipolar Disorder _____
Migraine Headache _____

Misc.
Smoking _____
Alcohol Use _____
Anemia _____
Glaucoma _____
HIV Infection _____
_____
_____

Male
Elevated PSA _____
Erectile Disorder _____
Prostate Enlargement _____

Female
LMP _____
Last Pap Smear _____
H/O Abnl Paps _____
# of Pregnancies _____
Contraception _____
Sexually Active _____

Personal History of Cancer
Brain Cancer _____
Thyroid Cancer _____
Breast Cancer _____
Colon Cancer _____
Lung Cancer _____
Prostate Cancer _____
Leukemia _____
Lymphoma _____
Ovarian Cancer _____
Cervical Cancer _____
Uterine Cancer _____
Kidney Cancer _____

Family History
Heart Attack _____
Hypertension _____
Heart Disease _____
Heart Failure _____
Blood Clots _____
Asthma _____
Chronic Lung Disease _____
Cancer _____
Diabetes _____
Depression _____
Anxiety _____
Mental Illness _____
Alcoholism _____
Alzheimer's _____
Seizure Disorder _____
Migraine Headaches _____
Stroke _____
Kidney Disease _____

Past Surgical History

Cardiovascular
Aneurysm Repair _____
Heart Bypass Surgery _____
Carotid Artery Surgery _____
Heart Valve Replacement _____
Pacemaker _____
Defibrillator _____
Stent Placement _____

Musculoskeletal
Hip Replacement _____
Knee Surgery _____
Knee Replacement _____
Shoulder Surgery _____
Rotator Cuff Repair _____
Carpel Tunnel _____
Lower Back Surgery _____
Neck Surgery _____

Genitourinary
Kidney Removal _____
Kidney Stone Surgery _____
Vasectomy _____
Prostate Surgery _____

Gastrointestinal
Appendix Removed _____
Gallbladder Removed _____
Colon Resection _____
Colostomy Bag _____
Ileostomy Bag _____
Weight Loss Surgery _____
Hemorrhoid Surgery _____
Pancreas Removal _____
Spleen Removal _____

Hernia Repair
Incisional _____
Inguinal (groin) _____
Umbilical _____
Abdominal _____

Other
Lung Surgery _____
Thyroid Surgery _____
Cateract Surgery _____
Ear Tubes _____
Tonsils Removed _____
Adnoids Removed _____

OB / GYN
Total Abd. Hysterectomy _____
with ovary removal _____
Vaginal Hysterectomy _____
Tubal Ligation _____
Cesarean Section _____
Mastectomy _____
Lumpectomy _____
Breast Augmentation _____
Breast Reduction _____

HARRISONVILLE FAMILY MEDICINE

2820 E. Rock Haven Road, Ste 100
Harrisonville, MO 64701
Phone (816) 380-3582 Fax (816) 380-6964

Patient Name | Social Security Number | Date of Birth

Releasing records ***FROM:*** _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Releasing records ***TO:*** _____
(physician or organization name)

_____
(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

_____ Confined to records for the time period of: _____

_____ Confined to records regarding the specific information: _____

_____ All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

For the purpose of: _____

This authorization is voluntary. This authorization will expire _____ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I request that records be copied and sent to me that the office will send those records to me within thirty (30) days. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for those costs. I understand that once the requested records leave HFM, they are the responsibility of the patient/ recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/ recipient will be responsible for providing a flash drive for the electronic copy.

_____
Signature of Patient or Legal Representative | Date

_____
If Signed by Legal Representative, Relationship to Patient | Signature of Witness

Patient Name: _____ Patient DOB: ___/___/_____ Date

Wellness Update

Do you experience any of these symptoms?	*Yes*	*No*
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

How often do you experience these symptoms?

- ☐ Occasionally (2-3 times per year)
- ☐ Over 3 times a year
- ☐ A few long periods of time per year (Spring, Summer, Fall, Winter)
- ☐ Most of the year

Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms? ☐ Yes ☐ No

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1 – 2 years

- ☐ Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- ☐ Re-occurring Seasonal Colds
- ☐ Chronic colds (lasting longer than 2 months)
- ☐ Migraine Headaches
- ☐ Restless sleep, challenges sleeping through the night, snoring
- ☐ Consistent or Re-occurring coughing
- ☐ Feeling of fatigue, irritability, & restlessness
- ☐ Asthma
- ☐ Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: _____ **Date:** ___/___/_____

Patient Phone: _____

FOR PROVIDER USE ONLY:
Order Allergy Test: ☐ Yes ☐ No
Date of last ENT exam: ___/___/_____

Provider Signature: _____ **Date:** ___/___/_____