Bibb Family Practice Associates, PC
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Patient Registration Form

Patient Name: _____ D.O.B._____

Social Security Number: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Partnered

Race: _____ ☐ Hispanic ☐ Non-Hispanic Language: _____

Address: _____ City/State/Zip: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Preferred Number: (check one) _____Home _____Cell _____Work

Patient Employer: _____ Employer Phone# _____

Email Address: _____ **Pharmacy:** _____

Emergency Contact: _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____

MEDICAL HISTORY

Allergies:

_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Social History:

Occupation/Former Occupation: _____

Tobacco use? ☐ YES ☐ NO - If YES, how many cigarettes per day? _____ How long? _____

Caffeine use? ☐ YES ☐ NO - If YES, how many cups per day? _____ How long? _____

Alcohol use? ☐ YES ☐ NO - If YES, how many drinks per week? _____ How long? _____

Recreational drugs? ☐ YES ☐ NO - If YES, what type? _____ How long? _____ How much? _____

Family History:

Father: Living? ☐ Yes, Medical Conditions: _____
☐ No, Cause of Death: _____

Mother: Living? ☐ Yes, Medical Conditions: _____
☐ No, Cause of Death: _____

Other medical problems within the family: _____

Medications:

_____

_____

Billing & Insurance Information:

Payment Method: ☐ Insurance ☐ Self-pay (If self-pay, please continue to Patient-Practice Policies)

Primary Insurance:

Policy Holder: _____ D.O.B: _____

Social Security#:_____Relationship to Patient: _____

Insurance Company:_____

Policy Number: _____ Group Number: _____

Is patient covered by additional insurance? ☐ YES ☐ NO (If YES, please continue)

Secondary Insurance:

Policy Holder: _____ D.O.B: _____

Social Security#:_____Relationship to Patient: _____

Insurance Company:_____

Policy Number: _____ Group Number: _____

Is patient covered by additional insurance? ☐ YES ☐ NO

(If YES, patient does have Tertiary Insurance information, we will obtain a copy of your insurance card)

Assignment & Release: (Initial: _____)

I have insurance coverage with the company(s) listed above and assign and authorize payment directly to Bibb Family Practice (BFP) and/or the providers at BFP all medical benefits, if any otherwise payable to me for services rendered. I understand and acknowledge that this Assignment does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to BFP, by any insurance policy, self-insurance program or other benefit plan. I hereby authorize the doctor to release of all information necessary to secure the payment of benefits, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS confidential information, and any health care related utilization review or quality assurance activities or any health care professional requiring this information. I also authorize BFP to file appeals on my behalf to insurance companies for payment of claims. I authorize the use of this signature on all my insurance claim submissions. Lastly, I acknowledge that this authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I further understand that I have the right to receive a copy of this authorization.

Medicare/Medigap/Medical Authorization:

Medicare ID Number:_____

I request that payment of authorized medical benefits and, if applicable Medicare Supplemental benefits, be made on my behalf to Bibb Family Practice and/or the providers at Bibb Family Practice for any services furnished to me by them. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medicare Supplemental insurer, and their agents any information needed to determine these benefits or benefits for related services.

Consent of Treatment: (Initial: _____)

Bibb Family Practice (BFP) employs a team approach to the delivery of your health care. Throughout your treatment we will work to understand your treatment needs. To accomplish this, an initial evaluation is completed, and information is collected about the problems you may be experiencing. Upon the completion of any additional diagnostic testing, a follow-up evaluation will be scheduled, and a course of treatment will be provided.

Medical services will be provided not only by your primary care physician, but all Primary Care Physicians, Physician Assistants, Nurse Practitioners, Nurses, and Medical Assistants employed by BFP. Medical services and treatments modalities include evaluation and management services, diagnostic ultrasound, laboratory testing, nutritional counseling, educational classes and pharmaceutical therapies. BFP may refer you to a treatment provider for other services that we believe are necessary at any time. We will assist you in coordinating these services to ensure that you receive the quality and timely services that you are entitled to receive.

Your signature below acknowledges that you understand and agree to the following:

- I am giving my consent to be seen and evaluated by the Providers of BFP.
- I acknowledge that I have been informed of my rights under Georgia Law to have my prescriptions given to me by a Nurse Practitioner/ Physician Assistant reviewed by my Primary Care Physician before filling it at the pharmacy, if I chose to do so.
- I have chosen to receive medical services from BFP. I understand that my choice has been voluntary and that I may terminate treatment at any time. I also understand that there is no assurance I will feel better.
- I also understand that my treatment is a collaborative effort between myself and BFP, and that I will attempt to work with BFP, to develop and follow a plan of treatment, and have the right to make an informed decision whether to accept or refuse treatment.

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

Street Address: _____ **City/State/Zip:** _____

Health Information Release: (Initial: ___)

I authorize Bibb Family Practice to release information about my health to the following person(s) listed below. Please note that unless listed below, they will not have access to your medical record, including your spouse. I understand that the people listed above will have access to my medical record. I understand that if in the future this list changes that I am solely responsible for making any necessary changes.

1. Name: _____ Relationship: _____
   Address: _____ Phone: _____
2. Name: _____ Relationship: _____
   Address: _____ Phone: _____
3. Name: _____ Relationship: _____
   Address: _____ Phone: _____

Authorization for Release of Medical Information

I hereby authorize the use, disclosure, and release of confidential health information about me to the practice listed below. Please Include in my medical record all office notes, lab results, medical imaging reports and any other pertinent information in my medical record so that I may receive the best possible care. (Initial: _____)

Practice Requesting Records From:	Please remit all records to:
Name: _____ Address: _____ Address 2:_____ City/State/Zip: _____ Phone: _____ Fax:_____	Bibb Family Practice Associates 721 Riverside Dr Ln, Macon, GA 31201 Macon, Georgia 31201 Phone: 478) 259-3439 Fax: 478-254-2733

Disclosure Notices for Patient/Patient Representative:

1. I understand that the information in my medical records may include information relating to my health in addition to my personal information such as my name, and/or my child's name, date of birth, address, etc.
2. I hereby specify that this authorization extends to cover the release of information related to HIV testing and/or the treatment of AIDS related complex, or AIDS related conditions in addition to psychiatric and/or drug and alcohol abuse treatment Information.
3. I understand that I may refuse to sign this authorization. My refusal to sign will not change my ability to get treatment, payment for treatment or eligibility for benefits. I may inspect or copy any information that has been either used or disclosed under this authorization.
4. I understand that I may revoke this authorization at any time by submitting a written request to the director of the organization where I am sending the Authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I acknowledge that I am the patient or am authorized to act on behalf of the patient and have read and fully understand this information. I was not coaxed or forced to give this consent. I understand that this authorization expires 90 days after the date of signature. I understand that at any time I may request a copy of this document for my personal records.

To the best of my knowledge, the above information is complete and accurate. I understand that it is my responsibility to inform my physician if I ever have a change in my health status.

_____

Printed Name of Patient & Authorized Patient Representative

X_____ _____

Signature of Patient/ Authorized Patient Representative Date

Review of Systems:

Patient Name:_____Date of Birth:_____**(Initial: _____; Date: _____)**

General:	**Yes**	**No**		**Ear, Nose & Throat:**	**Yes**	**No**
Weight Change in the last 6 months?				Coughing?		
Loss of Appetite?				Nosebleeds?		
Fever?				Hearing Loss?		
Weakness/ Fatigue?				Sore Throat?		
Gastroenterology:	**Yes**	**No**		Ringing in the Ears?		
Mouth Dryness?				Sinus Pain?		
Blood in/ Black Stool?				Pain/Difficulty in Swallowing?		
Nausea?				Runny Nose?		
Heartburn?				Itchy Eyes?		
Abdominal Pain?				Ear Fullness?		
Diarrhea?				**Respiratory:**	**Yes**	**No**
Constipation?				Difficulty breathing lying down?		
Hemorrhoids?				Shortness of Breath?		
Cardiology:	**Yes**	**No**		Chest Congestion?		
Dizziness?				**Musculoskeletal:**	**Yes**	**No**
Chest Pain?				Neck Pain?		
Palpitations?				Back Pain?		
Leg Edema?				Muscle Aches?		
Varicose Veins?				Shoulder Pain?		
Endocrinology:	**Yes**	**No**		Gout?		
Heat Intolerance?				Joint Pain/Stiffness?		
Excessive Thirst?				Joint Swelling?		
Diabetes?				Leg Cramps?		
Cold Intolerance?				Osteoporosis?		

Urology:	**Yes**	**No**		**Neurology:**	**Yes**	**No**
Kidney Stones?				Numbness?		
Foamy Urine?				Difficulty Concentrating?		
Difficulty Urinating?				Difficulty Comprehending?		
Blood in Urine?				Weakness?		
Frequent Urination?				Headache?		
Loss of Bladder Control?				Tingling/Numbness?		
Recurrent UTI?				Seizures?		
Nighttime Urination?				Insomnia?		
Male:				Memory Loss?		
Erectile Dysfunction?				Abnormal Gait?		
Prostate Problems?				**Dermatology:**		
Female:				Itching?		
Vaginal Discharge?				Sweating?		
Vaginal Bleeding?				Hair Loss?		
				Rash?		