Welcome to Family Care of the Fox Cities. We are happy that you chose us as your health care physicians.

Enclosed is the Registration Forms packet. In your Registration packet, a Release of Information is enclosed. If you could please complete this form and return it to me in the enclosed envelope, I can forward it to your previous physician and get your medical records transferred to us.

Please complete the other forms and bring them along to your first visit, along with your insurance card. If a copay is required by your insurance, it will be due at the time of the visit.

If you have any further questions or need assistance before your next scheduled visit, please contact our office. If at any time you need a physician (day, night or weekend), you can reach the office at (920) 730-2747 and follow the prompt to reach the on call physician.

We look forward to seeing you for your appointment!

NEW PATIENT APPOINTMENT CHECKLIST

________ Registration Form

________ Signature on File Form

________ Prescribing Consent Form

________ Race & Ethnicity Form

________ Minor Consent to Treat (if applicable)

________ Insurance Card (So that we can make a copy for your file)

_________ Photo Identification or 2 other forms of identification

________ Patient Communication Agreement (if applicable)

________ Medical History Form (Please complete and bring to your first visit)

________ Review of Systems Form (Please complete and bring to your first visit)

________ Release of Information Form (Please complete and return in the envelope provided for your convenience)

________ Office Visit Copay

Family Care of the Fox Cities, SC   Acct#________

PLEASE PRINT CLEARLY

Patient Information:

First Name__ ______________________ Middle Initial ______ Last Name__________________________________
(legal)

Address__________________________________City_________________State_______Zip_________

Home Telephone__________________Cell Telephone___________________ Social Security______________________

Sex M F_Birthdate______ Marital Status____ Email Address (if child) Parents' Names_____________

Guarantor: (responsible for bills)

First Name________________________Middle Initial_____Last Name_____________ ______Birthdate_________

Billing Address__________________________________City_________________State_______Zip_________

Home Telephone__________________ Cell Telephone__________________ Social Security_____________________

Employer Information:

Employed___Y N Employer_____________________________Telephone Number_____________________

Insurance Information:

Primary Insurance Company___________________________Address____

File/Group Number_________________Policy Holder Name ______________________Identification/ Subscriber Number________________

Employer______________________________________Employee Birthdate_____________________

Secondary Insurance Company___________________________Address____

File/Group Number_________________Policy Holder Name______________________Identification/ Subscriber Number________________

Other Information:

Referral Source____________________________________Primary Dr__________________________

Referral Doctor_______________________ Communication Limits?____________________________ ___________

Emergency Contact (not in household) Name____

Address_________________________________Telephone Number__________________ Relationship________

Members of Family Seen Here____

Primary Pharmacy and Location____

I AFFIRM THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

Responsible Party's Signature_________________________________Date_____________________

Family Care of the Fox Cities, S.C.
W3124 Van Roy Road
Appleton, WI 54915

Patient's Name______________________________________Birthdate____________

I understand that I am financially responsible for charges not covered by my insurance plan(s) and charges in excess of benefits paid under such plans. I will also be responsible for any services that my insurance company should decide are "non-covered" benefits.

I authorize release of any medical or billing information necessary to process claims incurred at this office. I further authorize billing statements to be sent to the person that I designate on my patient registration sheet as my responsible party (guarantor) including but not limited to my spouse.

I agree to the collection of any amounts I may owe and to be contacted by wireless or landline telephone number, voice mails, texts, written statements, autodial calls, and pre-recorded messages, which could result in charges to me. I agree to inform the office of new and updated information. This right and information may be passed on to collection agents and servicers. I understand that I may change my mind by notifying the office about my contact information.

I authorize direct payment to Family Care of the Fox Cities, S.C. of all medical insurance benefits including major medical payments otherwise payable to me.

Upon submitting a statement of informed consent to release of confidential medical information, I or a person authorized by me may:

Inspect my health care records during business hours, upon reasonable notice
Receive a copy of my health care records upon payment of reasonable costs
Receive a copy of my x-ray reports or have my x-rays referred to another health care provider of my choice upon payment of reasonable costs.

This meets the "signature on file" requirement. This authorization is in effect until I choose to revoke it and can be revoked at any time.

Responsible Party's Signature___________________________________Date________

I authorize my provider to communicate with other healthcare entities, as necessary for the provision of healthcare. I will also allow my blood to be tested for HIV infection in the event that a health care provider or employee is significantly exposed to my blood or body fluids. This information will be confidential and not released without permission. This authorization is in effect until I choose to revoke it.

Responsible Party's Signature__________________________________Date_________

OVER

FAMILY CARE OF THE FOX CITIES-page 2

Patient Name____

I will be offered a copy of the Privacy Practices at Family Care of the Fox Cities, S.C. This notice provides a more complete description of the uses of my health information. I have the right to request in writing restrictions on how my records may be used or disclosed. Family Care of the Fox Cities, S.C. is not required to agree to restrictions.

Responsible Party's Signature__________________________________Date_________

I authorize Family Care of the Fox Cities' staff to call me and either leave word on my answering machine or with another family member with a request to return their call regarding results and/or answers to simple questions.

Responsible Party's Signature_______________________________Date_________

I authorize the staff of Family Care of the Fox Cities to remind me by telephone of my future appointments including leaving word on my answering machine or with another family member. No mention will be made of the reason for the appointment.

Responsible Party's Signature_________________________________Date_________

PRESCRIBING CONSENT FORM

We now manage your medications on a system that checks for risks to you based upon your age, gender, weight, health problems, and all medications and supplements that we have prescribed, you have told to us, or your insurance company has paid. Because of privacy rules, we need your signature to manage your prescriptions. This is the only way we can prescribe now.

In addition, computerized prescribing allows for an accurate, legible, and understandable prescription to be sent directly to a pharmacy. The ability to electronically send a prescription is an important element in providing quality patient care. This method of prescribing greatly reduces medication errors and enhances patient safety by

- Using formulary and benefit transactions – gives the physician information about drugs which might be covered. (not all insurances provide formularies)
- Medication history transactions – provides the physician with information about medications a patient is already taking to minimize the number of adverse drug events.

By signing this consent form, I agree that Family Care of the Fox Cities, S.C., can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I agree that I have been informed that Family Care of the Fox Cities, S.C, uses a computerized prescribing program to provide my prescriptions. I am aware that I can ask questions about prescribing until my questions have been answered to my satisfaction.

____

Print Patient Name Date of Birth

____

Signature of Patient or Legal Guardian (Relationship to Patient) Date

NAME____DOB_____________

We are required to request the following information by the Federal Government:

RACE (please check one)

O **American Indian or Alaska Native**
(Definition: origins in any of the original peoples of North and South America and maintains tribal affiliation)

O **Asian**
(Definition: origins in any of the original peoples of the Far East, Southeast Asia, or the subcontinent of India)

O **Black or African American**
(Definition: origins in any black racial groups of Africa

O **Native Hawaiian or Other Pacific Islander**
(Definition: origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

O **White**
(Definition: origins in any of the original peoples of Europe, the Middle East, or North Africa)

O **Multiracial**
(Definition: having more than one or a combination of the above origins)

O **Declined**
(Definition: unwilling to choose a race category or cannot identify with one of the listed races)

O **Unavailable**
(unable to respond)

ETHNICITY (please check one)

O **Hispanic or Latino**
(Definition: Cuban, Mexican, Puerto Rican, South or Central American decent, regardless of race)

O **Non-Hispanic or Latino**
(Definition: Non-Hispanic or Latino - not of Hispanic or Latino ethnicity)

O **Declined**
(Definition: unwilling to provide an answer to the ethnicity question or cannot identify Hispanic or Not Hispanic)

O **Unavailable**
(Definition: physically unable to respond)

LANGUAGE (please check one)

O **English**

O **Other**_____________________

METHOD OF CONTACT BY US

(check all allowed by Family Care)

O **Mail**

O **Phone** O **Home** O **Cell** O **Work**

O **Fax** ______________________

W3124 Van Roy Road, Appleton, WI 54915
P: 920-730-2747 F: 920-730-2207

MINOR CONSENT TO TREAT

I, Parent/Guardian____

Address____

City/State/Zip____

Telephone Numbers____
(Home) (Alternate Number)

Insurance Company
Name & Numbers____

Of____
(Minor Patient Name) (Birthdate)

grant permission for Family Care of the Fox Cities, S.C., to authorize medical and hospital treatment for my above named child/ward in the event that I cannot be contacted through reasonable efforts.

This consent is for the time period of _______________to________________
(today's date) (until age 18)
and can be revoked at any time.

I hold harmless the physicians and staff who act in reliance with this authorization.

_________________________________ _________________________________
(Parent/Guardian Signature) (Witness Signature)

_________________________________ _________________________________
Date of Signature) (Date of Signature)

PATIENT COMMUNICATION AGREEMENT

Patient Name______________________________________ DOB_____________

These individuals may have access to my information and records at all times:

Name	Relationship	Telephone Number	RECORD TYPE
____________	____________	____________	___Medical ___Billing
____________	____________	____________	___Medical ___Billing
____________	____________	____________	___Medical ___Billing

Communication with an individual of my choosing may be made by:

______Telephone ______Written ______Verbal (in person)

I realize that my privacy may not be protected because of my communication choices. Regardless, I agree to release information about my records and me as I have directed. I will hold Family Care of the Fox Cities, S.C., harmless for any breach of confidentiality that occurs because of my directions for communicating health care information. I may revoke all or any part of this agreement at any time.

This Communication Agreement takes the place of any previous Communication Agreements on file at this facility. Yes_______ No_________

____

Signature of Patient or Legal Guardian (Relationship to Patient) Date

____

Witnessed by Date

Reviewed 12/4/17

Date of visit ____________________
Medical Record # ________________
Name __________________________
Date of Birth ___________________

List all allergies you have and type of reaction(s) you had:

Allergies to medications

____

____

Topical allergies (e.g. latex, iodine, metal, bandage)

____

____

Other allergies

____

____

List all prescription and non-prescription medications you take (include vitamins and supplements):

NAME	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

PAST MEDICAL HISTORY – MEDICAL DIAGNOSES

List Illnesses and Hospitalizations (other than surgery or obstetrics):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Surgical History (List all operations in your lifetime - include month & year):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Trauma History (List all major injuries in your lifetime – include fractures or severe concussions):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Obstetrics

Number of pregnancies: _____ Number of miscarriages: ______ Number of children deceased: ___

Number of live births: _______ Number of children living: _____ Number of C-sections: _________

Problems with pregnancies: ______________________________

Date of immunizations

Tetanus ______________________________ Other ______________________________

FAMILY HISTORY - Is there a history of the following diseases in your blood relatives? Include grandparents, aunts, uncles, and cousins.

DISEASE	WHO	AGE WHEN DIAGNOSED
Alcoholism		
Anxiety		
Asthma		
Cancer (include type)		
Depression		
Diabetes		
Glaucoma		
Heart disease (include type)		
High Blood Pressure		
Kidney disease (include type)		
Osteoporosis		
Seizures		
Stroke		
Thyroid disease		
Other Illnesses		

Any blood relatives with reaction to anesthesia:

Describe: ______________________________

Mother

Year of birth (or age at death and cause): ______________________________

Health status: ______________________________

Father

Year of birth (or age at death and cause): ______________________________

Health status: ______________________________

Grandparents (health status or age at death and cause):

Maternal GM ____________________ Paternal GM ____________________

Maternal GF ____________________ Paternal GF ____________________

SOCIAL HISTORY

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Name of significant other: ___________
Number of children: __________________ Year of birth and sex: ___________________________________
____

Highest education achieved: ____
High School ____________ Year graduated _______ College ______________ Year graduated ______

Employment - Full time or Part time? Describe: ____

Military History: _____________________ Branch of Service: ____________________________________

Tobacco - have you used regularly? Yes ______ No ______

If yes:	Age started	How long	Amt. per day	Still use? Yes/No	Quit date
Cigarettes	___________	___________	___________	________________	_______________
Other	___________	___________	___________	________________	_______________

Alcohol - do you regularly consume? Yes ____ No ____ If yes, amt. per week/month ______________

Do you use illegal drugs such as marijuana, cocaine, ecstasy etc.? Yes _______ No ______
If yes, which one(s) ____

Caffeine (i.e.: coffee, tea, soda) - do you regularly consume? Yes _______ No ______
If yes, amt. per day/week ____

Do you wear seat belts? All the time___ Most of the time___ 50% of the time___ Occasional___ Never ____

Do you have a history of physical or verbal abuse? Yes _______ No ______
Do you have a history of sexual abuse? Yes _______ No ______

Describe your overall activity/exercise level: Sedentary _____ Limited ______ Moderate ______
Strenuous ______ Regular aerobic and strengthening ______

Do you have a spiritual belief? Yes _____ No ______ If yes, please specify: _________________________

Treatment preferences:
Who is your Power of Attorney for Health Care (if any)? _____________________________________
May we have a copy for your chart? ____
Powers of Attorney for Health Care forms are available at our front desk.

NAME ____________________________________ **DOB**___________________

APPT WITH DR__________________________ **VISIT DATE**______________

REVIEW OF SYMPTOMS

DO YOU HAVE ANY RECENT OR ONGOING SYMPTOMS LISTED BELOW:

Constitutional Symptoms: Yes/No/NA (not applicable)

Are you in good health..___/__/___
Fatigue..___/__/___
Recent fever ....___/__/___
Chills ....___/__/___
Night sweats..___/__/___
Recent weight change ....___/__/___
Other ....___/__/___

Eyes:

Wear contacts or glasses ....___/__/___
Eye pain ....___/__/___
Redness ....___/__/___
Discharge ....___/__/___
Loss or blurring of vision..___/__/___
Double vision ....___/__/___
Other ....___/__/___

Ears, nose, mouth, throat:

Hearing loss ....___/__/___
Ringing in ears ....___/__/___
Ear pain ....___/__/___
Ear drainage ....___/__/___
Nasal obstruction/discharge ....___/__/___
Sinusitis..___/__/___
Snoring..___/__/___
Nosebleeds ....___/__/___
Tooth or gum problems...___/__/___
Sore tongue or mouth sores..___/__/___
Sore throat...___/__/___
Hoarseness ....___/__/___
Difficult swallowing ....___/__/___
Other ....___/__/___

Cardiovascular: Yes/No/NA

Chest pain or pressure ....___/__/___
Heart racing, skipping or irregular.......................................___/__/___
Angina...___/__/___
Blood pressures running high ....___/__/___
Blackouts, faints or loss of consciousness ....___/__/___
Shortness of breath at night..___/__/___
Difficulty walking two blocks due to leg pain ....___/__/___
Swelling in ankles or feet..___/__/___
Other ....___/__/___

Respiratory:

Difficulty breathing...___/__/___
Wheezing ....___/__/___
Coughing at night...___/__/___
Cough (persistent) ....___/__/___
Sputum production...___/__/___
Coughing or spitting up blood ....___/__/___
Other ....___/__/___

Gastrointestinal:

Cramping or abdominal pain ....___/__/___
Nausea..___/__/___
Heartburn or indigestion ....___/__/___
Vomiting ....___/__/___
Vomiting of blood...___/__/___
Frequent diarrhea ....___/__/___
Painful bowel movements...___/__/___
Constipation ....___/__/___
Blood in stool or black stools..___/__/___
Hemorrhoids or piles..___/__/___
Other ....___/__/___

Male Genitourinary:

Burning or painful urination ....___/__/___
Frequent urination..___/__/___
Leakage of urination ....___/__/___
Blood in urine ....___/__/___
Change in urine stream ....___/__/___
Difficulty in emptying bladder...___/__/___
Night time urination...___/__/___
Bedwetting ....___/__/___
Discharge from penis ....___/__/___
Testicular pain or swelling...___/__/___

Problems with sexual function ....___/__/___
Other ....___/__/___

Female Genitourinary: Yes/No/NA

When was the first day of your last menstrual period ....___/__/___
Burning or painful urination ....___/__/___
Frequent urination ....___/__/___
Leakage of urine ....___/__/___
Urinary urgency ....___/__/___
Blood in urine ....___/__/___
Night time urination ....___/__/___
Vaginal itching ....___/__/___
Vaginal discharge ....___/__/___
Abnormal periods ....___/__/___
Painful periods ....___/__/___
Spotting between periods ....___/__/___
Hot flashes or flushes ....___/__/___
Vaginal bleeding since menopause ....___/__/___
Painful sexual activity ....___/__/___
Pelvic pain ....___/__/___
Breast lumps or nipple discharge ....___/__/___
Other ....___/__/___

Musculoskeletal:

Neck pain ....___/__/___
Back pain ....___/__/___
Muscle pain ....___/__/___
Joint pain and swelling ....___/__/___
Other ....___/__/___

Skin:

Skin rashes ....___/__/___
Lumps, bumps or moles you are concerned with ....___/__/___
Changes in hair ....___/__/___

Neurological:

Headache ....___/__/___
Localized or persistent weakness ....___/__/___
Generalized weakness ....___/__/___
Persistent tingling or numbness ....___/__/___
Seizures ....___/__/___
Tremors ....___/__/___
Dizziness ....___/__/___

Psychiatric: Yes/No/NA

Anxiety or excessive worry ....___/__/___
Appetite disturbance ....___/__/___
Sleep disturbance ....___/__/___
Difficulty concentrating ....___/__/___
Memory problems ....___/__/___
Moodiness or irritability ....___/__/___
Low self esteem ....___/__/___
Hopelessness ....___/__/___
Depression..___/__/___
Suicidal thoughts or attempts ....___/__/___
Obsessive thoughts or compulsions ....___/__/___
Disturbing thoughts or feelings ....___/__/___
Attention deficit disorder ....___/__/___
Other ....___/__/___

Endocrine:

Increased thirst ....___/__/___
Heat or cold intolerance ....___/__/___
Increased appetite and eating ....___/__/___
Excessive sweating ....___/__/___
Other ....___/__/___

Hematologic/Lymphatic:

Abnormal bruising or bleeding ....___/__/___
Other ....___/__/___

Allergic/Immunologic:

Itchy eyes ....___/__/___
Itchy nose ....___/__/___
Frequent sneezing ....___/__/___
Hives ....___/__/___
Other ....___/__/___

RELEASE OF INFORMATION

FROM: Name of Provider/Clinic________________________ **TO:** Name of Provider/Clinic_______________________

Address______________________________ Address_____________________________

City/State/Zip________________________ City/State/Zip________________________

For the purpose of medical evaluation and/or treatment, any information regarding the diagnosis and records for any treatment or exam including:

(PLEASE PUT INITIALS ON ALL LINES)

_____ Office notes, lab results, X-Ray reports, consultations
_____ Any drug and alcohol use
_____ Any mental health disease/defect or psychologic/psychiatric condition
_____ Any communicable disease, HIV antibody results (AIDS) or HIV(AIDS)
_____ Other ____

FOR THE FOLLOWING PERSON(S): (print)

NAME	DOB	RELATIONSHIP

Reason for Requesting ____

I understand that information used or disclosed as a result of this authorization may further be used or disclosed by someone who obtains that information and may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign. My refusal will not affect my ability to obtain treatment, receive payment or eligibility for benefits. This authorization is revocable in writing at any time except to the extent that the disclosure has already taken place.

If I choose, I may inspect (at no cost) or receive a copy (upon payment of a reasonable cost) of the disclosed information. A fax copy or photocopy of this authorization shall be considered as valid as the original. This authorization is effective for 60 days from signing or for ___________________________(no longer than 1 year)

____

Signature of Patient or Legal Guardian (Relationship to Patient) Date

Witnessed By____