JMJ Family Practice
A place of Healing and Wholeness for the entire family

Patient Registration Information

Please PRINT and complete ALL sections below

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ /____ /____ Social Security # ____ - ____ - ____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ /____ /____ Social Security # ____ - ____ - ____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

PATIENT'S PERSONAL INFORMATION

Please present insurance cards to receptionist

Primary Insurance Name: _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

Name of Insured:_____ Date of Birth:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy #:_____ Group #: _____ Copay: $ _____

Secondary Insurance Name: _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

Name of insured:_____ Date of Birth:_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy #:_____ Group #: _____ Copay: $ _____

PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

PHARMACY INFORMATION

Name: _____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

Phone: (____) _____ Fax: (____) _____

EMERGENCY CONTACT

Name: _____ Relationship:_____

Address: _____ Apt.#:_____ City:_____ State:_____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits •Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to JMJ Family Practice Inc., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

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Full Name:_____ **Todays Date:**_____

Date of Birth:_____ **Gender**☐Male ☐Female

Allergies: Food, Pollens, Odors, Medicines, Pets, etc…

Current Medications, strength and dosage:

Current Herbs/Vitamins/Homeopathy/Supplements and what dosage:

Have you had any surgeries? ☐Yes ☐No If yes, when and for what:_____

Physical Traumas? ☐Yes ☐No If yes, when and what happened?_____

Any siginificant past medical history?

Family past medical history: check all that apply

Mom/Dad

☐☐ Asthma
☐☐ Allergies
☐☐ Arthritis
☐☐ Cancer
☐☐ Diabetes
☐☐ Headaches
☐☐ High Blood Pressure
☐☐ Tuberculosis
☐☐ Bleeding Disorder
☐☐ Mental Illness
☐☐ Liver Disease
☐☐ Seizures
☐☐ Thyroid Disorder
☐☐ Stroke
☐☐ Heart Disease
☐☐ Other: _____

Does the patient have any history of STD's? ☐Yes ☐No

Does the patient have a history of mental health? ☐Yes ☐No

Social History (Check all that apply)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation: ☐ Retired ☐ Homemaker ☐ Student ☐ Other:

Do you live alone, with a roommate, with family, or with a significant other? _____

Do you have children and If so, how many? _____ **Age(s)?** _____

Lifestyle/Self-care issues

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many per day: _____ #of years: _____

Did you ever smoke? ☐ Yes ☐ No if yes, when did you quit: _____

Do you drink alcohol? ☐ Yes ☐ No if yes, at what frequency: _____ How much: _____

Do you drink caffeinated beverages? ☐ Yes ☐ No if yes, which type: _____ Frequency: _____

Do you use recreational drugs? ☐ Yes ☐ No if yes, which type: _____ Frequency: _____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often: _____

Preventative Screening

Last Physical exam: _____

Last Colonoscopy: _____

Lat Mammogram: _____

Last Pap Smear: _____

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Patient Information Request

In order to provide you with the best service possible, we ask that you provide the information requested below.

Your Full Name: _____

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Pharmacy information is needed in order to process prescription electronically.

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Acknowledgement of Receipt of Notice of Privacy Practice

We maintain the privacy of medical and health information of any individual for whom we provide services and endeavor to comply with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. We abide by the terms of this Notice, as amended from time to time. JMJ Family Practice reserves the right to modify the privacy practices as outlined in the notice.

Acknowledgement

I have received a copy of the Notice of Privacy Practices for JMJ Family Practice, Inc.

_____

Patient Name (Print)

_____

Patient Signature

_____

Patient Representative Signature (if applicable)

_____

Relationship to patient

_____

Date

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Financial Policy

We are committed to providing you the best care possible and keeping you informed about the charges for your services and obligations.

1. Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; if you agree to have your insurance company pay the doctor directly. In the event that the insurance company does not pay JMJ Family Practice within a reasonable time, you will be billed for the services given. If a payment from the insurance company is received after you have paid for services, we will refund any overpayment to you.
2. Prior arrangements have been made with many insurance companies and health care plans to accept assignment of benefits. They will be billed directly and you will be required to pay a co-payment at the time of service.
3. If we do not have a prior arrangement with your insurance plan, we will prepare and send the claim for you on an unassigned basis. The insurance company will send the payment to you and you will be responsible for payment at the time of service.
4. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered," you will be responsible for payment of service. Payment is due upon receipt of a statement from JMJ Family Practice.
5. Your insurance company will be billed for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the financial policy; I agree to be bound by the terms. I also understand that such terms may be amended by JMJ Family Practice.

_____

Patient Name (Print)

_____ _____

Patient Signature (or responsible party) Date

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Missed Appointment Policy

Staywell, Healthease and Medicaid Only

Our practice is committed to providing the best treatment to our patients, please help us better serve you by keeping you regularly scheduled appointments.

All appointments must be cancelled 24 hours prior to your scheduled appointment, failure to cancel your appointment as stated in our policy three (3) times will result in the patient being discharged along with the patient's family members. A thirty (30) day grace period will be given for emergency care only.

Feel free to contact us if you have any questions or concerns.

I have read and understand the missed appointment policy and agree to abide by the guidelines.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date