ALEXANDRIA PRIMARY CARE
Patient Registration & Update Form

TODAY'S DATE:_____ ____

LAST NAME: _____

FIRST NAME: _____ **MI**: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

SEX: ☐ MALE ☐ FEMALE **PREFERRED LANGUAGE**: _____

PLEASE CHECK ONE BELOW:

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ WHITE
- ☐ MORE THAN ONE RACE
- ☐ I DECLINE TO ANSWER

ARE YOU HISPANIC OR LATINO?

- ☐ YES
- ☐ NO
- ☐ I Decline to answer

SSN: _____ **Date of Birth**: mm / dd / yyyy _____

HOME ADDRESS (STREET):_____ **APT#**:_____

CITY, STATE , ZIP: ZIP: _____

PHONE NUMBER: _____**ALT PHONE**:_____

WORK PHONE #: _____

EMERGENCY CONTACT NAME: _____

PHONE: _____ **ALT PHONE**:_____

RELATIONSHIP TO SELF: _____

EMAIL ADDRESS: _____
I hereby give Alexandria Primary Care permission to send lab and other test results to my email address. I understand that information sent over the internet is not secure and may be viewed by strangers. I understand that Alexandria Primary Care cannot guarantee the confidentiality or security of information sent over the internet.

SIGNATURE: _____

MY INSURANCE INFORMATION IS CURRENT, AND I HEREBY GIVE ALEXANDRIA PRIMARY CARE PERMISSION TO BILL MY INSURANCE COMPANY FOR ANY SERVICE RENDERED AND TO BILL ME DIRECTLY FOR ANY SERVICE NOT COVERED BY MY INSURANCE.

SIGNATURE:_____

ALEXANDRIA PRIMARY CARE ASSOCIATES
INSURANCE INFORMATION

IF YOU HAVE ALREADY PROVIDED US WITH A COPY OF YOUR INSURANCE CARD THEN PLEASE ONLY FILL OUT THE HIGHLIGHTED AREAS. IF YOU DO NOT HAVE YOUR CARD PRESENT WITH YOU THEN PLEASE FILL OUT THE COMPLETE FORM.

PATIENT NAME:_____ DOB:____/____/____
M D Y

PRIMARY INSURANCE COMPANY NAME:_____

INSURANCE COMPANY CLAIMS ADDRESS:_____

City: **State:** **Zip:**

MEMBER ID #:_____ GROUP #:_____

COPAY: $_____ INSURANCE PHONE #:____(_____)_____

POLICY HOLDER NAME **(IF DIFFERENT)**:_____ MALE ☐ FEMALE ☐

DOB:____/____/____ SOCIAL SECURITY #:_____-_____-_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE COMPANY NAME:_____

INSURANCE COMPANY CLAIMS ADDRESS:_____

City: **State:** **Zip:**

MEMBER ID #:_____ GROUP #:_____

COPAY: $_____ INSURANCE PHONE #:____(_____)_____

POLICY HOLDER NAME **(IF DIFFERENT)**:_____ MALE ☐ FEMALE ☐

DOB:____/____/____ SOCIAL SECURITY #:_____-_____-_____ RELATIONSHIP TO PATIENT:_____

SIGNATURE:_____ DATE:____/____/____

NOTICE: WITHOUT ALL OF THIS INFORMATION THE PATIENT WILL BE A **SELF-PAY** UNTIL WE GET THE COMPLETED INSURANCE INFORMATION

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT
Personnel at Alexandria Primary Care Associates are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent, or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION
I understand that my medical records and billing information are made and retained by Alexandria Primary Care Associates and are accessible to office personnel. Alexandria Primary Care Associates may use and disclose medical information for operations, functions , and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. Alexandria Primary Care Associates and its medical staff are authorized to disclose al or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the charges of Alexandria Primary Care Associates, and to any health care provider who is, or may become, involved with my care. Federal law requires that this office advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to, hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. Office personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS
I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY
I understand that this office will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY
As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by Alexandria Primary Care Associates.

CERTIFICATION
I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____ _____
Patient or Patient's Legal Representative Relationship to Patient

/ /
_____ _____
Date Signed Witness

RELEASE OF PROTECTED HEALTH INFORMATION
Information may be released to the following individual(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

I authorize confidential messages to be left on:

_____my answering machine at home _____
Home Phone

_____my answering machine at work _____
Work Phone

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by Alexandria Primary Care is in our Notice of Privacy Practices, which you have received. A copy is posted in this office.

I have received a copy of Notice of Privacy Practices.

_____ _____
Patient or Patient's Legal Representative Relationship to Patient

/ /
_____ _____
Date signed Witness

ALEXANDRIA PRIMARY CARE CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

(Please complete both pages of the health history questionnaire for review with your physician)

NAME:_____ **DATE OF BIRTH:_____/_____/_____**

PAST MEDICAL HISTORY

Place a checkmark (✓) next to the conditions you have now or have had in the past.

☐ Abnormal Pap	☐ Drug Dependency	☐ Mumps
☐ AIDS/HIV	☐ Emphysema	☐ Pacemaker
☐ Alcoholism	☐ Fibromyalgia	☐ Pneumonia
☐ Anemia	☐ Gallbladder Disease	☐ Polio
☐ Anorexia	☐ Glaucoma	☐ Prostate Problems
☐ Appendicitis	☐ Gout	☐ Psoriasis
☐ Arthritis	☐ Hay Fever / Allergies	☐ Psychiatric Care
☐ Asthma	☐ Head Injury	☐ Rheumatic Fever
☐ Bleeding Disorder	☐ Heart Disease	☐ Scarlet Fever
☐ Blood Transfusion	☐ Hepatitis	☐ Seizures
☐ Breast Lump	☐ Hernia	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Suicide Attempt
☐ Cataracts	☐ High Cholesterol	☐ Tonsillitis
☐ Chicken Pox	☐ Hormone Therapy	☐ Tuberculosis
☐ Colitis	☐ Kidney Disease	☐ Typhoid Fever
☐ Congenital Disorder	☐ Measles	☐ Ulcer(s)
☐ Depression	☐ Migraine	☐ Vaginal Infection
☐ Diabetes	☐ Mononucleosis	☐ Venereal Disease
☐ Diverticulosis	☐ Multiple Sclerosis	☐ Other Illness:

Women Only:

Age started menses _____	# days in cycle _____	# of live births _____	# of Abortions _____
# of days Bleeding _____	# of pregnancies _____	# of miscarriages _____	Contraceptive Method:

CURRENT ALLERGIES, SENSITIVITIES, INTOLERANCES

List anything you are allergic/sensitive to (medication, foods, chemicals, etc.) and how each affects you.

Allergic to…	*Effect*

CURRENT MEDICATIONS

List all medications you are now taking, including those you buy without a prescription. List name, dose, and how often per day.

Name	Dose	Often

PAST HOSPITALIZATIONS / SURGERIES

Please list all the times you have been hospitalized, or had an operation

Year	Hospitalization for…	Illness / Injuries	Surgeries

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

NAME:_____ **DATE OF BIRTH:_____/_____/_____**

FAMILY HISTORY

Please fill in health information about your family.

Relationship	*Age if living*	*Age at death*	*State of Health OR Cause of Death*
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			

Have any blood relatives had any of the following? If so, indicate relationship to you.

Illness	*Family Member*
Alcoholism	
Arthritis	
Asthma/Emphysema	
Blood Disease	
Cancer	
Colitis	
Diabetes	
Drug Dependency	
Heart Disease	
High Blood Pressure	
Mental Problems	
Migraine	
Stroke	
Suicide	
Tuberculosis	
Other:	

SOCIAL PROFILE

(These questions are for you to go over with your physician at your appointment)

Where were you born?	Have you ever had a problem with drugs/alcohol?
Level of education?	Do you ever use illegal/recreational drugs?
Current employment?	Do you drink alcohol?
Recent change in job?	How many drinks per day?
Marital status?	Are you exposed to fumes/solvents?
Living with (spouse/ significant other / roommate/ family)	Are you exposed to loud machinery?
How often do you exercise?	Do you regularly wear a seatbelt?
What exercise do you do?	How do you define your sexual orientation?
How much coffee/tea do you drink per day?	Is your sex life satisfactory?
Have you ever smoked?	Do you have a pet, if so what type and how many?
How many cigarettes per day? For how many years?	Are there firearms present in your household?
What year did you quit smoking?	Are there smoke detectors in your residence?

Have you traveled outside the U.S. in the past two years? *Where?* *When?*

When was your last….Tetanus _____ *Pneumococcus* _____ *Rubella* _____ *Hepatitis B* _____
Measles _____ *TB Skin Test* _____ *(pos / neg)* *Influenza* _____ *Mumps* _____

Please list any other physicians/providers who are treating you: