Your health and well-being are important to us and are our first priority. The following policies are currently in effect:

- Please bring all medication bottles (prescription and over-the-counter supplements) to each and every visit. This will help to improve safety and accuracy.
- All prescriptions for controlled medications (i.e. sleep aids, anxiety medication, pain medication, etc.) are issued for a period of 30-days at a time, there are no additional refills. For all other prescriptions, please allow 24 to 48 hours when requesting refills.
- Patients must call to cancel appointments at least 24 hours prior to the appointment time. If you fail to contact us, you will be considered a no-show. Three consecutive no-shows may result in discharge from the practice.
- Please carefully read the demographic and medications forms given to you at every visit. This is your chance to update all necessary information such as phone number, address, insurance, medication, etc. Bring driver's license, insurance card(s) and co-payment (if applicable) to each and every visit.

Thank you for choosing AtlantiCare for all your health care.

Patient Registration Form

Patient Information:
Reason for visit (if injury how did it occur):
____

If injury, is it related to: Worker's Comp? Y / N   Motor Vehicle? Y / N

Please give date of injury: --/--/----__

First Name: ____________________Middle initial: ____last Name: _______________

Social Security # ______/_____/_____ Date of Birth: ___/___/____Age: ____________

Sex M / F / T   Marital Status (circle one) S M D W Partner

Address____

City _____________________State _______Zip _________

Home Phone # (_____) _____________Cell Phone # (____) _____________

Work (__) _____-_______

Emergency Contact Information (if patient is an adult) orParent/Guardian Information (if patient is a minor):

First Name________________________ Middle Initial: ___Last Name: ____________________

Relationship to Patient: ________________________Home Phone #: (_____) _______________

Work Phone (_____) ________________Cell phone # (____) ________________________

Employment Status (circle one) Full-time / Part-time / Self Employed / Retired / Military

Patient's Occupation _____________________________Work # _________________________

Employer _____________________Address_________________________________

City __________________________________State ___________Zip_________

Is it okay to leave messages at: Work? Y / N__If Student, indicate School _____________
Student Status FT/ PT

Do you have an Advance Directive? Y / N If no would you like information about it? Y / N

Insurance Information:

Name of PRIMARY Insurance ____

If Medicare: Is the patient a Veteran? Y / N Are you currently employed? Y / N

Do you have a Federal Black Lung Card? Y / N Is your spouse/partner currently employed Y / N

Policy / Subscriber # ______________________________________ Group # _______________

How is the Subscriber related to you? Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name _______________________ Middle Initial _______ Last Name _______________

Social Security # _____ /_____ /_____Date of Birth: ___/___/___Age: ______Sex M / F / T

Address ____

City ______________State___________ Zip ________

Home Phone # (____) ________________Cell Phone # (_____) _______________________

Subscriber's Employer ____

Work # (____) _______________Employer's Address __________________________________

City ______________________ State _____ Zip:___________________

Name of SECONDARY Insurance Company ____

Policy / Subscriber # ____________________________________Group # _________________

How is the Subscriber related to you? Self / Spouse / Child / Guardian/ Partner

Policyholder / Subscriber Information:

First Name _______________________ Middle Initial _______ Last Name __________________

Social Security # _____ /_____ /_____Date of Birth: ____/___/___Age: ______Sex M / F / T

Address ____________________________City _____________________ St _____Zip________

Home Phone # (____) ____________________Cell Phone # (____) ____________________

Subscriber's Employer ____________________________ Work # ________________________

Employer's Address ____

City ________________________ State _____ Zip _______________

Additional Information

E-mail address _____________________ preferred method of contact Home / Cell / Email

Is it okay to leave messages at: Home? Y / N Cell? Y / N

Primary Language ____________________ Country of Origin __________________________

Translator services required? Y / N

Ethnicity _______________ Race ______________

Are you visually impaired? Y / N

Are you hearing Impaired? Y / N

Pharmacy Information:

Retail Pharmacy Name: _______________________________________

Phone # (____) __________ Fax # (____) __________ Location _____________________

ID# ____

Mail Order Pharmacy: ____

Phone # (_____) _________________ Fax # (____) _________________

ID # ____

Preferred lab Company:

- ☐ AtlantiCare Labs (ACL)
- ☐ Lab Corp
- ☐ Quest

Primary Care Physician: ____

Referring Physician: ____

Today's Date ____/____/______

Patient's Name: _____________________________DOB: ____________________________

MEDICAL HISTORY: (please check all that apply)

High Blood Pressure	Drug Abuse
High Cholesterol	Alcohol Abuse
Diabetes	Ulcers
Cancer	Hepatitis
Tuberculosis	HIV
Urinary Tract	Thyroid
Infections	Asthma
Anemia	COPD
Kidney Stones	Stroke
Kidney Disease	Angina
Gallbladder Disease	Lyme's Disease
Heart Disease	Arthritis
Depression	Other (please describe)

Do you have any Allergies to Medication, food or other: **Y / N**

Surgical History: (please list type of surgery, if any, and date)

Family History: (please check all that apply)

Blood Pressure	Stroke
Diabetes	Heart Attack
Cancer	Kidney Disease
Other (please describe)	Depression

Social History

Alcohol:	**Y / N**	If yes, how many drinks are consumed, per week? __________
Cigarettes:	**Y / N**	If yes, how many packs per day? __________

Other treating providers: (please list the name and specialty of any other provider currently treating you)

Name: ___________________________ Specialty: ___________________________
Name: ___________________________ Specialty: ___________________________

Today's Date: _______/ _____/ ______

Patient Name: ________________________________ DOB: _____/ _____/ _______

Please list all medications including vitamins and over the counter supplements and medications

Medication	**MG/ Strength**	**Dose/ How Often**

***NOTE:** It is always best to bring in your all medication, supplements and vitamins to all your medical visits.

Consent to discuss Care & Treatment

Patients Name: ________________________________Birthdate: ______/______/_______

Practice Name_________________________________ Primary Provider __________________

I permit the following information to be discussed with the following family member, friend or others person or persons listed below.

I understand that if I want any of the persons listed below to receive a copy of my records; I must complete and sign a separate authorization form.

In an emergency or if I am admitted to the hospital and unable to make my wishes known, I understand that my provider and hospital staff may rely on the above permissions to determine with whom they may discuss my care.

I can change the permissions stated below at any time by notifying my provider or AtlantiCare's Privacy office.

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill Name Relationship Phone

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill Name Relationship Phone

- ☐ Appointments only
- ☐ Results/ Plan of care ____
- ☐ My bill Name Relationship Phone

Patient signature____Date____________________________

Print name____

Signature of lawful personal representative* _________________________________Phone________________

Print name____

*Required only if the patient is a minor or unable to represent self.