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) or Parent/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)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td>Drug Abuse</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>Alcohol Abuse</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Cancer</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>HIV</td>
</tr>
<tr>
<td>Urinary Tract</td>
<td>Thyroid</td>
</tr>
<tr>
<td>Infections</td>
<td>Asthma</td>
</tr>
<tr>
<td>Anemia</td>
<td>COPD</td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>Stroke</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Angina</td>
</tr>
<tr>
<td>Gallbladder Disease</td>
<td>Lyme’s Disease</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Depression</td>
<td>Other (please describe)</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Stroke</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Cancer</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Other (please describe)</td>
<td>Depression</td>
</tr>
</tbody>
</table>

**Social History**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Y / N</th>
<th>If yes, how many drinks are consumed, per week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cigarettes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Specialty</td>
</tr>
</tbody>
</table>
Today’s Date: ______/ _____/ ______

Patient Name: ____________________________________ DOB: _____/ _____/ ______

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>MG/ Strength</th>
<th>Dose/ How Often</th>
</tr>
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<tbody>
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</tbody>
</table>

*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

Name

Relationship

Phone

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.