LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

DANIEL ISLAND FAMILY MEDICINE

Patient Registration Form

Date_____

Patient Name: (Parent/Guardian Information MUST be filled out BELOW if the patient is a minor)

First _____ M.I._____ Last_____

Date of Birth: _____/_____/_____ SSN: _____ Sex: F M

Address: _____ City: _____ State: _____ Zip: _____

Martial Status: Single Married Divorced Widowed Other

Home# (_____) _____ Cell# _____ Email Address:_____

Preferred Local Pharmacy: _____ (used to electronically send prescriptions when possible)

In order to have access to your Medication History, Liberty Doctors needs your authorization (PBM Consent). Y N

Employer: _____ Work Phone: (_____) _____

Preferred Language: _____ Race _____ Ethnicity: _____

Emergency Contact Name: _____ Phone Number: _____

Patient/Legal Guardian Signature _____ Date: _____

Liberty Doctors Employee Witness Signature _____ Date: _____

Responsible Party for Care & Payment Info (mandatory for minors & patients with legal guardians)

Relationship to Patient_____

First _____ M.I._____ Last _____

Date of Birth: _____/_____/_____ SSN: _____ Sex: F M

Address _____

Phones: Home (_____) _____ Cell _____ Work_____

Insurance Information

Primary Insurance Co. _____ Policy number: _____

Policyholder Name: _____ Date of Birth: _____SSN: _____/____/_____

Secondary Insurance Co. _____ Policy number:_____

Policyholder Name: _____Date of Birth: _____ SSN: _____/_____/_____

Third Insurance Co. _____ Policy number:_____

Policyholder Name: _____ Date of Birth: _____ SSN: _____/_____/_____

Consent for Treatment, Assignment of Benefits & Release of Information

Thank you for choosing Liberty Doctors (LD) to meet your medical needs. We are dedicated to providing the best treatment available. **Carefully read and initial each section and sign and date the bottom.**

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by LD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand no guarantee has been or can be made as to the results of treatments or examinations at LD.

Initials_____

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize LD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to LD. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for LD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize LD to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review LD Notice of Privacy Practices in the office upon request.

Initials_____

Acknowledgement of Receipt of Notice of Privacy Practices

I , _____hereby acknowledge that I have received the Notice of Privacy Practices (as defined by HIPAA) for Liberty Doctors.

Signature: _____ Date:_____

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DANIEL ISLAND FAMILY MEDICINE

New Patient Medical History

This information helps us in providing you with the best medical care and treatment. Please fill out the form completely. If you have questions, please ask the nurse or front desk receptionist. Thank you and we look forward to seeing you today!

Patient's Name: _____ Today's Date: _____
Date of Birth: ___/___/___

Medications. Please list ALL medications you are currently taking (including over-the-counter and vitamins/ supplements). Continue list on back of this sheet if needed.

Medication	*Dose*	*How Often*

Medication allergies. Please list.

Medication Allergy	*Reaction*

Latex Allergy? Y N Adhesive Allergy? Y N

Medical History of Patient. Please indicate if you are currently, or have ever, experienced the following:

Heart Disease	Y	N	Seizure	Y	N
High Blood Pressure	Y	N	Anxiety	Y	N
High Cholesterol	Y	N	Depression	Y	N
Stroke	Y	N	Other Mental Illness	Y	N
Diabetes	Y	N	*(if yes, type _____)*		
GERD	Y	N	Cancer	Y	N
Asthma	Y	N	*(if yes, type _____)*		
Thyroid Disease	Y	N			

Other unlisted medical problems _____

Social History

Do you smoke?	Y	N	If yes, how many cigarettes per day? _____
Any other forms of tobacco?	Y	N	List _____
Do you drink alcohol?	Y	N	How often?_____
Do you use any illicit drugs?	Y	N	Marijuana ____ Cocaine ____ Other _____

New Patient Medical History (cont.)

Marital Status: Married Single (never married) Divorced Separated Widowed

What is your occupation? _____
What is your highest level of education? _____

Family History

Is your **mother** □ living or □ deceased? Is your **father** □ living or □ deceased?
Does/has anyone in your family (living or deceased) have the following? (please explain all that apply)
High Blood Pressure:_____
High Cholesterol:_____
Cancer (type?): _____
Stroke:_____
Heart Disease:_____
Diabetes:_____
Depression:_____
Mental Illness (please be specific):_____
Thyroid Disease: _____
Other: _____

Surgical History

Please select/list all surgeries:			Surgery Date (approximate):
Appendix	Y	N	_____
Tonsils/Adenoids	Y	N	_____
Hysterectomy	Y	N	_____
Gallbladder	Y	N	_____
C-Section(s)	Y	N	_____
Heart	Y	N	_____ *Type of surgery* _____

Other: _____

Females only

Last pap smear date_____ Abnormal? Y N
Last mammogram date _____

Patients 50+ years old

Last colonoscopy date _____

Men only 50+ years old

Last PSA date _____

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Financial Policy

Missed Appointments: A missed appointment fee may be charged if you do not show up for a scheduled appointment or cancel with less than 24 hours notice. This fee must be paid before a new appointment is scheduled.
Initials_____

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to new services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you fail to make payment arrangements or meet established payment terms, your account may be turned over to an outside collection agency (which incurs an additional fee) and you will be discharged from this practice.
Initials_____

Returned Checks: There is a $35.00 fee for returned checks. This fee plus your balance is due when you are notified of the returned check.
Initials_____

Insurance: We participate with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. A **Valid driver's license** and **insurance cards must be presented** at each visit. If you do not have your current insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.
Initials_____

Self-pay patients and patients who have not met their deductible are required to pay for services in full at check out. It is your responsibility to inform us of any changes to your insurance information. We request your assistance in following up with your insurance company to resolve any non-payment issues. Please be aware that services you receive may be non-covered by Medicare or other insurers. You are responsible for any and all uncovered portions of the bill. **Deductibles or co-pays must be paid on the date services being rendered.** Patients who are unable to pay for services as required can speak with our office manager to set up a payment plan.
Initials_____

Signature of Patient or Responsible Party: _____ **Date: _____**

Signature of Employee Witness: _____ **Date: _____**

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DANIEL ISLAND FAMILY MEDICINE

Designated Party Release

You may give Liberty Doctors, LLC written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

Date:_____ Account/Chart#_____

Patient Name: _____
Date of Birth:_____

I authorize **Liberty Doctors, LLC** to disclose my Protected Health Information (PHI) to the following individuals:

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

I authorize **Liberty Doctors, LLC** to communicate my Protected Health Information (PHI) to me via the following methods:

_____Detailed message on my home phone answering machine Phone:_____

_____Detailed message on my voicemail at work Phone:_____

_____Detailed message on my cell phone voicemail Phone:_____

_____Email detailed Medical Information Email: _____

Authorized Signature:_____ Date:_____

STOP – Cancellation Notice!
I understand that I may cancel this authorization at any time by signing the notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any actions taken by Liberty Doctors, LLC in accordance to this authorization prior to the receipt of written notice of cancellation.

Printed Patient Name:_____

Signature Authorizing Cancellation: _____ Date:_____

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DANIEL ISLAND FAMILY MEDICINE

Authorization for Release of Medical Records

Patient's name (please print): _____
Date of birth:_____
Phone number: _____

PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF PATIENT CARE

FROM:

Name of practice: _____
Practice fax:_____

TO:

Liberty Doctors, LLC dba Daniel Island Family Medicine
Edward Giove, D.O.
297 Seven Farms Drive, Suite 202, Daniel Island, SC 29492
Phone: 843-936-4470; Fax: 843-256-6877

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory/x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS.

Patient Signature_____ Date _____

Office Manager _____ Date _____