Adam S. Harris, MD, LLC
Phone: (205) 995-9700 Fax: (205) 995-9709
WWW.SurgeonAdamHarris.com

# PATIENT DEMOGRAPHICS & REGISTRATION

Date: _____ Preferred Language: _____

Full Name: _____ Marital Status: _____

Date of Birth: _____ Driver's License #/State: _____

Gender: _____ SSN: _____ Email: _____

Race: _____ Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐

Address: _____

Home Phone: _____ Cell Phone: _____

Preferred Method of Contact: Cell Phone ☐ Home Phone ☐ Can we leave a voice message? Yes ☐ No ☐

## EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone: _____ Status: Full-time ☐ Part-time ☐ Temp ☐

## EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship to Patient: _____

Contact Address: _____

Contact Home Phone: _____ Contact Cell Phone: _____

Do you have a Living Will or an Advanced/Medical Directive in the event you become unable to make decisions due to illness or incapacity? Yes ☐ No ☐

## INSURANCE INFORMATION

**Primary Insurance**

Insurance Name: _____ Subscriber: _____

Member ID: _____ Group No: _____

Relationship to Patient: _____

**Secondary Insurance**

Insurance Name: _____ Subscriber: _____

Member ID: _____ Group No: _____

Relationship to Patient: _____

## REFERRAL INFORMATION

Who should we thank for your visit?

☐ Physician _____ ☐ Website _____

☐ Friend _____ ☐ Other _____

Name: _____

Date of Birth: _____ Current Weight: _____ lbs. Height: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

## CURRENT MEDICATIONS

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

## ALLERGIES

1._____ 3._____ 5._____
2._____ 4._____ 6._____

## FAMILY MEDICAL HISTORY

| | Mother | Father | Sibling | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|
| Cancer | | | | | | | |
| Diabetes | | | | | | | |
| Heart Disease | | | | | | | |
| Mental Illness | | | | | | | |
| High Blood Pressure | | | | | | | |

## SOCIAL HISTORY

Do you smoke? _____ How often? _____ Do you drink alcohol? _____ How often? _____

## SURGICAL HISTORY

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

## PATIENT MEDICAL HISTORY

- ☐ Acid Reflux
- ☐ Alcohol Addiction
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis- Type:
- ☐ Atrial Fibrillation
- ☐ Blood Clot
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ COPD
- ☐ Cancer- Type:_____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Hernia
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pulmonary Disease
- ☐ Rectal Bleeding
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Other:_____

# ADAM S. HARRIS, MD, LLC

| Patient Name (Print) | SS or Health Record Number | Patient DOB |
|---|---|---|
| | | ____/____/____ |

_____ I authorize (practice/physician's name) to use or release/disclose my health information as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history and physical
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests you would like disclosed):_____
  _____
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
  _____
- ☐ Consultation reports (please supply doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose:

☐ My personal records

☐ Sharing with other health care providers as needed

☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease(s), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and /or treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name: _____ Name: _____

Address: _____ Address: _____

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ____/____/____

Patient Signature (or Signature of Person Completing Form if Not Patient*) Date

*Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Other:_____

Distribution of copies: original to practice, copy to patient, copy to accompany information released

## PRIVACY NOTICE

**Privacy Notice to Patient**: As an effort of good faith, we are required to provide the patient with information regarding our privacy practices and patient rights.

By signing below, the patient acknowledges being made aware of such privacy practices and has received a copy of the practice's Privacy Notice.

_____ _____

Patient's or Legal Guardian's Signature Date

_____

Printed Name of Patient or Legal Guardian

**FOR OFFICE USE ONLY**

☐ Patient refused to sign Privacy Notice

☐ Patient was unable to sign Privacy Notice for the following reason: _____

Employee: _____ Date: _____

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## RESPONSIBLE PARTY & FINANCIAL INFORMATION

**Authorization to Release Information**: The undersigned authorizes the practice to release any medical or other information about the patient which may be necessary for the proper filing of all insurance claims, review of services, or receipt of benefits.

**Assignment of Benefits**: The undersigned will furnish the necessary healthcare information to the practice and agrees to assist in processing all claims for benefits. The undersigned also assigns to and authorizes the direct payment of benefits to the practice. The patient further agrees to pay for services at the time of the appointment or (at the discretion of the practice), upon receipt of the service's first billing statement.

**Financial Responsibility**: The practice strives to provide the best possible medical care for its patients. We expect that we will be paid for services rendered. The undersigned agrees to be totally responsible for all charges for services rendered to the patient including any non-covered charges. The undersigned hereby consents to the release, disclosure, and documentation of his/her financial records to assist the practice with payment collection for services performed. The undersigned certifies that he/she is an authorized user of the disclosed financial accounts and agrees to electronic payment for said service amounts. In the event electronic payment is used for service collection, the undersigned agrees that any receipts may be mailed or emailed to the destinations provided during registration.

**Change of Information and Collections**: As it relates to collecting payment, should any personal information change (such as name, address, financial documentation, etc.), it is the patient's responsibility to contact the practice and notify them of such. The undersigned also agrees, that if the unpaid account is referred to an attorney for collection, to pay all costs of collection including reasonable attorney fees.

By the way of signature below it is confirmed that this document has been read, understood, and agreed thereto by the patient and responsible parties; any penalties contained herein shall be executed upon the failure to adhere to any terms of this agreement.

_____ _____

Patient/Legal Guardian or Responsible Party's Signature (**agreement to pay**) Date

_____ _____

Printed Name of Patient/Legal Guardian or Responsible Party Relationship to Patient