**ADONI HEALTHCARE SERVICES™**

**PATIENT REGISTRATION FORM**

Date _____

Patient Name (Last) _____ (First) _____ Date of Birth (mo/day/year) _____
Sex (what you were born as): Male/Female/Other – If "other" please specify: _____
Gender (what you identify as): Male/Female/Other – If "other" please specify: _____
SSN_____
Address _____ Zip Code _____
Home Tel# _____ Cell# _____ Email _____
Primary Care Provider _____ Phone# _____
Pharmacy Name _____ Phone# _____
Pharmacy Address _____
Patient's Employer _____ Work# _____
Employer Street Address _____
Marital Status _____
Spouse Name _____ Phone #_____
Spouse Address _____
In Case of Emergency _____ Relationship _____
Address _____
Phone# _____

What brings you in **today**? Please be **specific**:

**PAST MEDICAL HISTORY**

Hospitalizations — Date and Illness/Reason: _____
_____
_____
_____

Surgeries — Date and Type, including anybody implants such as cardiac stents, heart valves, joint replacements, pacemakers: _____
_____
_____
_____

Ongoing Medical Problems, including asthma, COPD, diabetes, heart disease, heart murmur, hepatitis, HIV/AIDS, hypertension, kidney failure, venereal disease, alcohol or drug addictions, present or previous psychiatric care
_____
_____
_____

Allergies — Name Drug and Reaction, including any type of anesthetic:
_____
_____

**CLINICAL HISTORY and CONDITION**

List of Prior/Ongoing Conditions conditions — Name / Frequency / Severity /Prior or Ongoing
1. _____

2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Prior Treatment(s), Name of treatment/Name of condition being treated/Duration/Outcome of Treatment

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

| Prescription Medication Name | Dosage | Regimen | Target Symptom |
|---|---|---|---|
| 1. _____ | | | |
| 2. _____ | | | |
| 3. _____ | | | |
| 4. _____ | | | |
| 5. _____ | | | |

Over The Counter/Vitamins/Supplements/Herbals/Homeopathies/Other Self-Medication

| Med Name | Dosage | Regimen | Target Symptom |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are You Currently Taking Aspirin, Coumadin, Plavix, Persantine, or other blood thinners?

_____

Preventative Care — List Ongoing Medical Treatments, Special Diets, Physical Therapies, etc.

_____
_____
_____

If Female, Are You Currently Pregnant or Think That You May Be? YES / NO

Date of Last Menstrual Cycle _____

Are You Planning on Getting Pregnant? YES / NO

Are you currently Breast-Feeding? YES / NO

**FAMILY MEDICAL HISTORY**

Hereditary Diseases, Significant Illnesses or Cause of Death of Grandparents/Parents/Children/ Siblings/Aunts/Uncles/Cousins, example allergy/bleeding disorders/cancer/heart disease/sickle cell anemia/psychiatric problems such as anxiety/bi-polar/depression, etc.

_____
_____
_____

**NUTRITIONAL HISTORY**

Special Dietary Needs _____
_____

**SOCIAL HISTORY and HABITS**

Coffee _____ cups/day Tea _____ cups/day Alcohol _____ drinks/day/week Tobacco _____ cigarettes/day How Many Years Have You Been Smoking? If You Quit, When Did You Stop?

_____

Do You Currently Use Marijuana? YES / NO

If YES, how often and by what method, does it help alleviate the symptoms of your qualifying condition?

_____
_____
_____

Recreational Drug Use — Frequency/Type/Route, i.e. ingestion, injection, snorting

_____
_____
_____

## OFFICE POLICIES

**Adoni Healthcare Services, LLC** and staff are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and practice.

### Participating Insurance

You must provide us with accurate insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not expired. If you receive services without obtaining a required referral, you will be financially responsible for such services.

### Self-Paying Patients

Payments for services are due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your claim, and/or provide you with an itemized bill, once all fees are paid.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services not covered by my insurance plan, if I have not obtained and presented a valid referral at the time services are rendered. I agree to pay for services and tests not covered by my insurance plan's regulations and procedures. I also request that this information to apply to any/all insurance(s).

**Patient Full Name** _____

**Date** _____

**Signature of Patient/Parent or Guardian** _____

## Notice of Privacy Practices Patient Acknowledgement Authorization for Use/Disclose of PHI

Patient Name _____ Date of Birth _____

### Acknowledgement of Privacy Notice

I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

### Authorization for Use/Disclose of Protected Health Information (PHI)

I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize **Adoni Healthcare Services, LLC** and its staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

_____

*List any person(s) that you are allowing this office to communicate with regarding your PHI*

### Patient Manner of Contact

In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

### ** I Wish To Be Contacted in the Following Manner

_____ NO RESTRICTION (Okay to call home and/or cell and leave detailed message)
_____ Restricted Method of Contact (Check all that apply below)
_____ Call your cell ONLY
_____ Call your home ONLY
_____ Other _____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.

**Signature** _____ **Date** _____

Relationship to Patient, if signed by a personal representative i.e. parent, legal guardian, etc

_____

**INSURANCE INFORMATION**

Policyholder's Name _____ Birth Date _____
Street Address _____ Phone# _____
Name of Insurance Co. _____ Group# _____
Address _____ Phone# _____

**SECONDARY INSURANCE INFORMATION**

Policyholder's Name _____ Birth Date _____
Street Address _____ Phone# _____
Name of Insurance Co. _____ Group# _____
Address _____ Phone# _____

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize **Adoni Healthcare Services, LLC** to furnish all necessary information to my insurance carriers concerning my (or my dependent's) illness and treatment and I hereby assign to the physician or supplier all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any co-payment for the office visit as designated by my insurance carrier. I understand that it is my responsibility to ensure that procedures/surgeries are part of my contract with my insurance carrier and I am responsible for payment if my insurance carrier does not cover the designated procedure.

_____

**Signature** **Date**

FOR MEDICARE PATIENTS: I hereby authorize **Adoni Healthcare Services, LLC** and staff to furnish all necessary information to my insurance carriers concerning my illness and treatment, and I hereby assign to the healthcare provider or supplier all payments for medical services rendered to me.

_____

**Signature** **Date**