OPTIMAL FAMILY CARE LLC

PATIENT REGISTRATION FORM

Patient Demographics

Patient Name: _____ DOB: _____ Gender: Male Female

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

Cell Phone: _____ Work Phone: _____ SSN: _____

Email: _____

Race:

☐ Asian ☐ Black/African American ☐ White

☐ Hispanic ☐ Native Hawaiian/Other Pacific ☐ Other: _____

Ethnicity:

☐ Hispanic or Latin American ☐ Non-Hispanic or Latin American ☐ Refuse to Report

Language:

☐ English ☐ Portugese

☐ Spanish ☐ Creole ☐ Other:_____

Insurance

Primary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Secondary Insurance: _____ Subscriber ID#: _____

Subscriber Name: _____ Relationship to Patient: _____

Emergency Contact

Name: _____ Relationship to Patient: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____Pharmacy City: _____ Pharmacy State: _____

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Assignment of Benefits

Consent for Treatment, Payment and Health Care Operations

By signing below, I understand that I hereby authorize the practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations. I understand that I am responsible for payments in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to Optimal Primary Care LLC. I also authorize Optimal Primary Care to release all information necessary for the processing of insurance claims to HCFA, its agents or any other insurance company to determine the benefits payable for related services.

Patient Signature: _____Date: _____

Insurance Waiver

This office will make every effort to submit bills for services rendered to you to your insurance and accept insurance rates as payment in full. In some cases, due to specific requirements, such as special contract, lack of referral, or another physician listed as primary care physician the insurance may deny payment. Charges, and payment thereof, will then become the responsibility of the patient.

I understand that, should my insurance not pay for my office visit or procedure, I will be responsible for payment of services.

Patient Signature: _____Date: _____

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New Patient History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your personal medical record.

PATIENT NAME: _____ **DOB**: _____

LIST ANY MEDICAL PROBLEMS

CURRENT MEDICATIONS

NAME OF MEDICATION	STRENGTH	FREQUENCY TAKEN

ALLERGIES

NAME OF DRUG	REACTION YOU HAD	NAME OF ALLERGEN	REACTION YOU HAD

SURGICAL HISTORY

DATE OF SURGERY	TYPE OF SURGERY	HOSPITAL

HOSPITALIZATION HISTORY

DATE OF ADMISSION	REASON	HOSPITAL

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Health Screening

Please check-mark the conditions that apply to you.

Condition:	Asthma/COPD	COVID-19	Heart Disease	Diabetes	Hyper-tension	Cholesterol	Depression	Alcohol/ Drug Abuse	Arthritis	Cancer

Preventive/Health Maintenance Questions:

If you are over 50, have you had a colonoscopy?	☐ YES ☐ NO ☐ N/A	Year Done: _____ Hospital/Office: _____ Result if known: _____
Have you had osteoporosis screening for low bone mass? (Bone Density Test)	☐ YES ☐ NO ☐ N/A	Year Done: _____ Hospital/Office: _____ Result if known: _____
If you are over 40, have you had a mammogram?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Hospital/Office: _____ Result if known: _____
If female, have you had a Pap Smear?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Physician/Office: _____ Result if known: _____
If male and over the age of 50, have you had a prostate cancer screening done in the past 2 years?	☐ YES ☐ NO ☐ N/A	Month/Year Done: _____ Physician/Office: _____ Result if known: _____
If diabetic, have you had a diabetic eye exam?	☐ YES ☐ NO ☐ N/A	If yes, Date Done: _____ Physician/Office: _____
COVID-19 Vaccine	Date: _____	Where: _____