Flat Rock Physicians
New Patient Registration

Last Name:	Registration Date:
First Name:	Deceased Date:
Preferred Name:	Homebound?
Middle Name, Suffix:	How did you hear about us?
Former Last Name:	**Do we have permission to call you?**
Sex:	Yes ☐ No ☐
Date of Birth:	Guardian Last Name:
SSN:	First Name:
Address:	Middle Name:
Address:	**Emergency Contact**
City:	Name:
Zip Code:	**Relationship**
State:	Home Phone:
Home Phone:	Cell Phone:
Work Phone:	**Relationship**
Cell Phone:	Phone:
Patient Email:	**Employment**
Contact Preference:	Employer Name:
Language Spoken:	Employer Phone:
Race:	Usual Occupation (current or most recent):
Ethnicity:	Usual Industry:
Marital Status:	**Mailing Address**
Guarantor Information Patient Relationship to guarantor:	Address:
Last Name:	Address:
First Name:	Zip
Middle Name, Suffix:	City:
	State:

There is a $50.00 No Show Fee/less than 24 hour cancellation for New Patients and a $50.00 No Show/less than 24 hour cancellation fee for established patients.

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorized my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by my signature as though the undersigned had personally signed the particular claim. I hereby authorize my insurance company(s) to pay and hereby assign directly.

David G. Patterson, DO, PC or Jennifer Fretz, DO, PLC, benefits, if any otherwise payable to me for his/her services. **I understand that I am financially responsible for all charges incurred. This contract supersedes any and all contract between your physician and your health insurance company.**

Signature:____ **Date:**_______________________________

Privacy Acknowledgement

I have received the notice of privacy practices and I have been provided with the opportunity to review it.

Signature:____ **Date:**_______________________________

Personal Representative's Name:____

Date:__________________________

Flat Rock Physicians

Jennifer Fretz, D.O. or David G. Patterson, D. O.

25620 Gibraltar Rd.

Flat Rock, Michigan 48134

Telephone: (734) 789-9355; Fax: (734) 789-1520

Request for Records Release

Date:____________________ **Patient Name:**____

DOB: ____________________ **SSN:**______________________________

Address:____

Hereby authorizes____ **(Name of doctor releasing records),**

Address:____

Phone Number:______________________________ **Fax Number:**________________________________

It's director or agent to release information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format. This included information concerning human immunodeficiency (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC), if any protected under the Michigan Public Act 174 of 2989, as amended; and substance abuse information, if any, protect under 42 Code of Federal Regulations, Part 2; and social and psychological services information, if any, including communications made to a social worker or psychologist if any to the individuals or organizations and only under the conditions listed below:

1. Jennifer Fretz, Do. O. or David G. Patterson, D. O. (circle one), 25620 Gibraltar Rd., Flat Rock MI 48134.
2. The purpose or need for such disclosure (circle one):

   Personal Use   Insurance

   Continuation of Care   Disability

   Attorney   Other

   Workman's Comp
3. Specific information to be disclosed/obtained as related to #2 (date of service):
   (Circle one):

   ER Memo   Discharge summary

   Outpatient Visit   Immunizations

   X-ray   Entire record

4. The authorization is valid only if received by the above listed physician within 90 days of the date signed. I may revoke the authorization anytime. Revocations will not apply to the information that had already been released pursuant to this authorization.
5. Information used/disclosed pursuant to the authorization may be subject to redisclosure by the recipient and will no longer be preceded by the rule.
6. The above-mentioned physicians reserve the right to charge for processing and copying information. The fee waived releasing information directly to a treating physician or health care facility.

I hereby authorize the release of all necessary medical records to Flat Rock Physicians. I wish them forwarded as soon as possible.

Patient Signature:___________________________________ **Date:**________________________________

Guardian Signature:___________________(if other than pt) **Date:**________________________________

Patient Address:____

City:____ **State:**_____ **Zip:**______________________

Signature of Witness:_________________________________ **Date:**________________________________

Patient Medication History Authority

Name:____ **Date:**________________________________

At Flat Rock Physicians, we are committed to providing excellent care while evolving with modern medical technology. We are pleased to announce our new electronic medical records (EMR) implementation powered by AthenaHealth, Inc. To make the EMR transition as seamless as possible, please review and sign the patient Medical History Authority agreement below. The Medication History Authority is an authorization that allows for an import and download of a patient's 13-month medication history into the EMR. The information collected only includes medications that were filled and paid for by the patient's health insurance. Thank you for your participation in this program as it maintains an accurate medication history for your records. This accurate history empowers us as physicians to better assist you at Flat Rock Physicians.

Sincerely,

Flat Rock Physicians

Consent

By signing this document, I the patient, give consent and authorize the use of Medical History Authorization to be implemented and utilized by Flat Rock Physicians' EMR services powered by AthenaHealth, Inc.

Patient Printed Name:____

Patient Signature:____

Date (Flat Rock Physicians): ___________________________________

Name:____ **Date:**________________________________

Flat Rock Physicians

Insurance Questionnaire

Your insurance company will only cover the following reasons for your visit today. Please check **ONE** box to explain the reason for today's visit.

_____ I am here for a PHYSICAL (sport, work, insurance, Medicare Wellness Exam, Healthy Blue Exam, etc.) and have **NO** problems, nor symptoms to discuss with the doctor today.

I DO NOT NEED REFILLS TODAY

I DO NOT HAVE A NEW PROBLEM OR OLD PROBLEM TO DISCUSS WITH THE DOCTOR.

______ I am here for a NEW MEDICAL PROBLEM, or to DISCUSS ABNORMAL TEST RESULTS.

OR

______ I am here for CHRONIC DISEASE MANAGEMENT and MEDICATION REFILLS.

1.
2.
3.

______ I am here for a PROCEDURE (skin, biopsy, pap smear, wart destruction, etc.)

______ I am here for a CLEARANCE FOR SURGERY or PAPERWORK.

Signature:____ **Date:**_______________________________

Flat Rock Physicians

Medical History Questionnaire

Problems	Check if "yes"	Additional Details
None of the below		
ADHD		
AIDS/HIV		
Allergies: seasonal or food		
Anemia		
Anorexia or Bulimia		
Anxiety Disorder		
Arthritis		
Asthma		
Birth defects or inherited disease		
Bladder or prostate problems		
Blood diseases, or blood type		
Broken bones or fracture		
COPD/Emphysema		
Cancer		
Chicken Pox (age)		
Colitis/Crohns or Irritable Bowel		
Constipation		
Depression		
Developmental or behavioral disorders		
Diabetes		
Diverticulosis		
Ear or hearing problems		
Fibromyalgia		
Gallbladder disease		
Gastrointestinal problems		
Gout		
Head injury/concussion		
Headaches		
Heart disease		
Heart murmur		
Hepatitis A, B, or C		
High cholesterol		
High blood pressure/hypertension		
Hospital admission other than birth		
Hypo or hyper thyroid		
Kidney disease or stones		
Liver disease		
Mental illness		
Muscle, joint, or bone problems		
Osteoporosis		
Pulmonary embolism		
Reflux/GERD		
Seizures/Epilepsy		
Sexual dysfunction		
Skin problems		
Stroke		
Tuberculosis		
Varicose veins		
Vision or eye problems		

Review of Systems

If you suffer from any of the following health problems, place a check in the space provided.

General	**Check if “yes”**	**Additional Details**
Weight loss		
Weight gain		
Fever		
Chills		
Eyes		
Blurred Vision		
Itchy Eyes		
ENT		
Dizziness		
Nose Bleeds		
Voice Change		
Hearing Loss		
GI		
Nausea or Vomiting		
Diarrhea		
Blood in Stool		
Heart		
Chest Pain		
Racing Heart Rate		
Leg Swelling		
Lungs		
Shortness of Breath		
New Cough		
Wheezing		
Endocrine		
Frequent urination		
Neuro		
Loss of memory		
Numbness		
Involuntary Movement		
Skin		
Rashes		
Itching		
Changes in Moles		
Psych		
Depressed Mood		
Sleep Disturbance		
Crying Spells		
Anxiety		
MS		
Joint Pain		
Stiffness		
GU		
Pain with urination		
Incontinence		
Weak Urine Stream		
None of the above		

Social History

Name:____ **Date:**_________________________________

Please circle the correct answer and fill in the blanks

1. Do you smoke now?   Yes or No

   Did you ever smoke for more than 1 month? Yes or No

   Year started: _______________ Year ended:______________

2. Did you graduate from high school, college, graduate school? (circle all that apply)

3. What is your occupation?____

4. Who is your employer?____

5. Number of children? ____________________________

6. Do you use marijuana?   Yes or No

   Do you use any street drugs? Yes or No

   Have you ever used a needle to inject street drugs? Yes or No

7. Do you currently chew tobacco?   Yes or No

8. Has your mother, father, sister or brother had a heart attack or stroke before the age of 60?

   Yes or No

9. Are you married, single, divorced, widowed, domestic partner, separated?____________________

10. Do you have a loaded gun in your home that is not locked up?   Yes or No

11. How many days per week do you exercise?____

12. How many alcoholic beverages do you drink each week?__________________________________

13. Are you right, left or ambidextrous handed?____

14. In a month’s time, how many days do you drink more than 5 alcoholic beverages?___________

15. Is your mother alive? Yes or No

    a. In what year was she born?_______________

16. Is your father alive? Yes or No

    a. In what year was he born?________________