PATIENT REGISTRATION INFORMATION (Please Print)

Please check: _____Dr. ____Mr. ____Mrs. ____Ms. ____Jr. ____Sr. (or) Other____________

Please check: Male_______Female ___________

Patient's Name (Last)____________________ (First)____________________ (Middle)______________

Date of Birth: ______________________ Social Security Number: ______________________

Also Known As: Name (Last)__________________________(First)______________________________

Physical Address____

City, State, ZIP____

Mailing Address____

City, State, ZIP____

Telephone: Home _________________ Work _________________ Cellular _____________________

Email Address: ____

Alternate Contact Name_______________________________________ Phone Number_____________

Patient Relationship to Alternate Contact __________________________ Phone Number_____________

Preferred Pharmacy_______________________________________ Phone Number_____________

Married Status: ____Married ____Single ____ Divorced ____Widowed ____Legally Separated _____Other

Employment Status: ___Full Time ____Part Time ____ Retired ____Self Employed ____Unemployed

Employer______________________________ Employer Address______________________________

Student: ____Full Time ____ Part Time

RESPONSIBLE PARTY INFORMATION

Same as above? ______Yes ______No Relationship to Patient ______________________________

Responsible Party Name (Last)__________________ (First) ________________ (Middle) ___________

Mailing Address: ____

City, State, Zip ____ Date of Birth: _________________

Co-Payment Amount _________________________

PRIMARY INSURANCE INFORMATION (Please provide insurance card to the front desk at check-in.)

Name of Insured ______________________________

Relationship to Patient ______________________ Please check: ____Male ____ Female

Date of Birth ____________________ Insured Party's Social Security #: ____________________

Insured Employer ______________________________

Insured Employer Address ______________________________

Insurance Company ______________________ Insurance Co. Tel. # ____________________

Insurance Company Address ______________________________

Subscriber ID (Policy Number) ______________________ Group ID ____________________

Co-Pay Amount ____________ Effective Date ____________ Termination date____________

SECONDARY INSURANCE INFORMATION (Please provide insurance card to the front desk at check in.)

Name of Insured ______________________________

Relationship to Patient ______________________ Please check: ____Male ____ Female

Date of Birth ____________________ Insured Party's Social Security #: ____________________

Insured Employer ______________________________

Insured Employer Address ______________________________

Insurance Company ______________________ Insurance Co. Tel. # ____________________

Insurance Company Address ______________________________

Subscriber ID (Policy Number) ______________________ Group ID ____________________

Co-Pay Amount ____________ Effective Date ____________ Termination date____________

Today's Date: ___________________________

Birth Date: ___________

I. Reason for today's visit: ____

____.

II.A. Surgeries and Serious Injuries:

	Type	Year
1.	______________________________	______
2.	______________________________	______
3.	______________________________	______
4.	______________________________	______
5.	______________________________	______

II.B. Serious Illness and Hospitalizations:

	Type	Year
1.	______________________________	______
2.	______________________________	______
3.	______________________________	______
4.	______________________________	______
5.	______________________________	______

III. Past Medical History: (circle positives)

a) High blood pressure, Heart attack, Heart disease, Stroke, Phlebitis, Blocked arteries, Rheumatic Fever.

b) Asthma, Tuberculosis or positive TB skin test, Emphysema, Pneumonia, Allergic rhinitis.

c) Gallstones, Hepatitis, Ulcers, Colon polyps, Diverticulitis.

d) Frequent urinary infections, Kidney stones, other Kidney disease, Prostate problems.

e) Diabetes, High Cholesterol, High Triglycerides, Thyroid disorder.

f) Osteoporosis, Arthritis, Gout.

g) Cancer (including skin cancer) Anemia.

h) Migraine, Psychiatric illness, Glaucoma.

i) Other. (Please describe.)

Periodic Health Screening:

Last: mammogram _________ Pap Smear __________ Colon exam _______ B/P exam ________

IV. Immunizations: Pneumonia Vaccine ____ Tetanus ____ Influenza ____

V. Family History

	Living	Dead	Age	Disease(s):
Mother	☐	☐	☐	________
Father	☐	☐	☐	________

			Disease(s)
Brother(s):	Number living	____,	________
	Number Deceased	____,	________
Sister(s):	Number living	____,	________
	Number Deceased	____,	________

Have any family members had any of the following diseases? (e.g. maternal aunt)

High blood pressure/Stroke/Diabetes. ________________________________

Heart Attack, Heart Disease. ________________________________

Cancer (Breast, Colon, Other). ________________________________

Hereditary/Genetic disorder, Bleeding disorder. ________________________________

VI. Lifestyle/Social History: (circle those that apply to you)

Marital Status: Single Married (how many times) _______, (how long) ______, (# of children) ______
Divorced _______, Widowed _______.

Last grade completed: Jr. High High School College Post Graduate Other

Current Occupation: ________________________________ Hours/Week __________

Former Occupation: ________________________________.

Diet (e.g. low salt): ________________________________.

Exercise (type/frequency): ________________________________/__________.

Hobbies and Interests: ________________________________.

Caffeine on a regular basis? Yes☐ No☐ How many cups/cans per day ________________.

Have you ever used tobacco products on a regular basis? Yes ☐ No ☐

Average number of cigarettes/day ______ Smoker for how long? _____ If quit, when? ____________.

Alcohol intake: None ☐ Occasional ☐ 1-2 Drinks/Day ☐ More Than 2 Drinks/Day ☐

Drugs: None ☐ Rarely ☐ Occasional ☐ Daily☐

Seat Belts: Do you use them? Yes ☐ No ☐ Percent of time _____%.

Do you feel your life is stressful? Yes ☐ No ☐ Why ________________________________.

How many hours of sleep/night ________________________________.

VII. List all Prescription medications that you are currently taking:

Drug Drug Strength Frequency

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________
9. ________________________________
10. ________________________________

VIII. List any non-prescription (over-the-counter) medicines that you take regularly: ________________

________________________________.

IX. List any medications which you cannot take or are Allergic to and Why: ________________

________________________________.

X. Systems Review (circle systems that apply to you or fill in the appropriate blank.)

1. **General**: Change in weight of more than 10 lbs. over the past year. Yes ______ No ______
2. **Head**: Severe or frequent headaches, visual problems, or hearing problems.
3. **Respiratory**: Persistent cough shortness of breath, or wheezing.
4. **Cardiovascular**: Chest pain/discomfort, palpitations.
5. **Gastrointestinal**: Pain or difficulty with swallowing, frequent or severe indigestion, abdominal pain. Recent change in bowel habits, chronic diarrhea or constipation. Blood in stools.
6. **Urinary**: Frequent or painful urination, frequent nighttime urination. Bladder leakage, difficulty emptying your bladder, sexual difficulties.
7. **Female/Ob-Gyn**: Last Pap smear or pelvic exam ____________, Age of Menopause _____________. History of abnormal Pap smears, abnormal-vaginal bleeding, recent vaginal discharge. History of estrogen use __________, breast discharge, breast lump(s), and breast pain. Perform self-exams. Yes ______ No ______. Last Mammogram _________. Number of pregnancies ________. Number of deliveries ________.
8. **Musculoskeletal**: Joint pains, chronic or severe back pain.
9. **Skin**: Chronic skin rash, skin lesions that are of concern to you.
10. **Neurological**: Frequent or severe dizziness, numbness or tingling of hands or feet, fainting spells.
11. **Mood**: Frequent or recurrent feelings of depression, nervousness, anxiety, or difficulty sleeping.

John J. Madej, M.D.
Internal Medicine
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PORTOLA VALLEY, CA 94028

PATIENT NAME:____

Assignment of Insurance Benefits:

I hereby authorize John J. Madej, M.D. and his billing company to apply for benefits and receive payments on my behalf for covered services rendered. In making this assignment, I agree that I am financially responsible to the above party for charges not paid under my insurance policy. I permit a copy of this authorization to be used in place of the original.

Release of Information:

I hereby authorize John J. Madej, M.D. and his medical billing company to disclose any or all parts of the clinical record to any insurance company covering these services for purposes of satisfying charges billed.

Medicare Patients:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me. I authorize any Financing Administration and it's agents to obtain any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the new charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND DOES UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

______________________________ ______________________

Signature of Patient of Patient's Agent, Representative or Guarantor

Date

Acknowledgment of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, ____ (Patient), acknowledge that I have received a copy of the Notice of Privacy Practices.

____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

____

Parent or Legal Guardian Date

____

Relationship to Patient

If the patient is not a minor, but under the care of a relative, friend, or caregiver, sign here.

____

Signature Date

____

Relationship to Patient