Abco Medical Center, L.L.C.

Family Medicine Practice

13535 Detroit Avenue Suite 4 . Lakewood, OH 44107. Phone : (216) 226-2626

PATIENT REGISTRATION

Name (Last, First, MI)_____

Address (include City, State, Zip)_____

Phone : Home ( )_____ Work ( )_____ Cell ( )_____

Email Address _____

Date of Birth_____ Gender : Male or Female Social Security #_____

Race (please circle one): White, Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, Other, Decline to Answer/Unknown

Emergency Contact:

Name_____ Relation_____

Phone Number_____ Address_____

Pharmacy Name_____ Pharmacy Number_____

INSURANCE INFORMATION

Insurance Company Name_____

Specific Plan Type (if applicable)_____

Member ID #_____ Group ID #_____

Name of Primary Insured_____

Secondary/Other Coverage

_____

_____

Who referred you to our Practice?_____

MEDICAL HISTORY AND SOCIAL HISTORY

Medical History Section (please circle applicable conditions):

AIDS	Alcholism	Allergies, Seasonal	Alzheimer's Disease
Anemia	Angina	Anorexia Nervosa	Anxiety
Arthritis	Asthma	ADHD	Bipolar
Bronchitis	Cancer	Cardiac Arrhythmia	Cirrhosis
Cholesterol	Colitis	Congestive Heart Failure	Dementia
Depression	Diabetes	Drug Addiction	Fibroids
Fibromyalgia	Gout	HIV Infection	Heart Attack
Headache	Hemorrhoids	High Blood Pressure	Hepatitis
Hodgkin's Disease	Incontinence	Infertility	Leukemia
Liver Disease	Lung Disease	Lupus	Melanoma
Menstrual Dysfun.	Migraine	Obesity	Osteoporosis
Parkinson's Disease	Pneumonia	Prostate Disease	Prostate, Enlarged
Pulmonary Embolism	Rheumatic Fever	Sexual Dysfunction	Scarlet Fever
Stomach Disorder	Stroke	Thyroid Disease	Tumors
Ulcer	Other_____		

Family History (please place an "X" in the box that relates the appropriate condition with the respective family member):

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Press.						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

Please list all current **Medications** you are taking:

Medication	Strength	Directions

Please list any **Medication Allergies** you have (include onset date):

_____

Please list any **Food Allergies** you have (include onset date):

_____

Please list any **Surgeries** you have had:

_____

Women Only: Are you pregnant? Y or N Are you planning pregnancy? Y or N

Social History Section (please answer the following):

What is your occupation?_____

Smoking Status:

- ☐ Current Smoker (Every Day)
  - Number of Packs per day_____
- ☐ Current Smoker (Some Days)
  - Number of Packs per day_____
- ☐ Former Smoker
- ☐ Never Smoked

Alcohol Usage:

- ☐ Current Alcohol Use (Circle: Daily, Occasionally, Rarely)
- ☐ Never Consumed Alcohol

Marital Status (circle one):

Married, Never Married, Divorced, Legally Seperated, Widowed

Number of Children:_____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

May this Practice:

1. -Call you at home regarding appointments & medical information? Y or N
2. -Call you on your cell phone regarding appointments & medical information? Y or N
3. -Call you on work voice mail regarding appointments & medical information? Y or N
4. -Speak with another person other than yourself regarding appointments & medical info? Y or N
   **Specify contact name, relation, and phone #_____
5. -May we send you appointment and medical information via postal mail? Y or N
6. -May we send you appointment and medical information via email? Y or N

7. Do you give this Office permission to access your drug information? Y or N

Please read the following pages on *Notice of Privacy Practices* (a poster is also located near reception window).

NOTE:
Please return these forms to the window, along with your insurance card and driver's license.

You will be instructed to provide 2 electronic signatures regarding your HIPAA consents and preferences.

Thank you.

I certify that the information I have provided above is true to the best of my knowledge.

Signature_____ Date_____

Abco Medical Center

Notice of Privacy Practice regarding Health Information Exchanges

Abco Medical Center, LLC participates in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying the Office Manager at Abco Medical Center, LLC by calling 216-226-2626. You may also download the "Request to Change Consent" form at www.abcomedicalcenter.com, under the tab "Forms".

I give permission to Abco Medical Center, LLC to access pertinent medical records regarding my health and treatment through the state-wide Health Information Exchange.

Name:_____

Signature:_____ Date:_____