Patient Registration Form

Patient Name: ____ ____________________
(Last) *(First)* *(MI)* *(Preferred name)*

DOB: _____-_____-_______ SSN #: _____-_____-_____ ☐ M ☐ F

Address: ________________________________ Race: _______________

City/Sate: _______________________________ Hispanic or Latino? ☐ Yes ☐ No

Email Address: ___________________________

☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Legally Separated

Home Phone: _____________________ Cell Phone: ___________________ Other Phone: __________________

Emergency Contact: ____ ______________________
(Name) *(Relationship)* *(Phone)*

Preferred Pharmacy and Location: ____

☐ Spouse ☐ Parent information (if patient is a minor, fill in both sections completely for each parent)

Name: _____________________________________ Name: _____________________________________

Address: ___________________________________ Address: ___________________________________

City/State/Zip: ______________________________ City/State/Zip: ______________________________

Phone: _____________________________________ Phone: _____________________________________

Employer: __________________________________ Employer: __________________________________

Primary Insurance

Name of Insurance: _______________________

Policy Holder: ___________________________

Relationship to Patient: ____________________

DOB: ______________ SSN: ________________

Address: ________________________________

Secondary Insurance

Name of Insurance: _______________________

Policy Holder: ___________________________

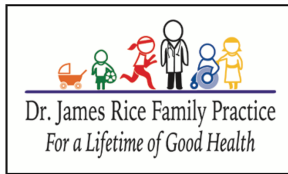
Relationship to Patient: ____________________

DOB: ______________ SSN: ________________

Address: ________________________________

Assignment of Insurance benefits and Financial Responsibility Agreement: I hereby authorize my signature on all insurance and Medicare claim forms at the office of Dr. James A. Rice D.o>, for payment to him for services rendered to me or the patient. I authorize this office to make and send copies of my/the patient's medical records that they may need to file my insurance claims. I understand that I am responsible for charges incurred regardless of whether my insurance pays or not. I understand and agree to pay any unpaid balances that may be assigned to a third party collection agency for collections or placed with an attorney to obtain judgement or otherwise satisfy payment of my account, a collection fee may be added to my account. I understand and agree to the terms above.

Signature: ____ Date: ______________________



Patient Medical History Questionnaire

Patient Name: ______________________ DOB: ______________ SSN #: ____-____-_____

Please list all your hospitalizations and/or surgeries (use back if necessary): ☐ Check here if none

Month/Year	Hospital	Reason

Please list all medical conditions and illnesses (i.e. Diabetes, high blood pressure, pneumonia, etc.) ☐ Check here if none

1) ______________________ 4) ______________________

2) ______________________ 5) ______________________

3) ______________________ 6) ______________________

Do you smoke?	☐ Yes	☐ No	
Do you drink alcohol?	☐ Yes	☐ No	How often? ______________
Do you eat a balanced diet?	☐ Yes	☐ No	
Are you on a special diet?	☐ Yes	☐ No	
Do you drink caffeine?	☐ Yes	☐ No	
Do you exercise?	☐ Yes	☐ No	How often? ______________
Have you ever struggled with drug and/or alcohol abuse?	☐ Yes	☐ No	

If yes, please explain: ____

____

Please list ALL current medications (prescription and over the counter ☐ Check here if none

1) ______________ 4) ______________ 7) ______________

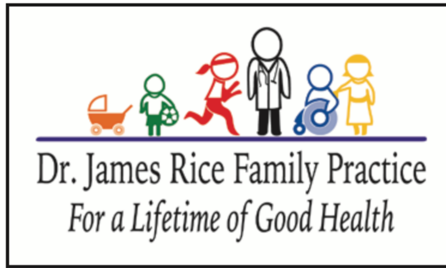
2) ______________ 5) ______________ 8) ______________

3) ______________ 6) ______________ 9) ______________

Have you been outside of the country in the last 30 days? ☐ Yes ☐ No

How would you rate your overall current health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor



Family History

Patient Name: ________________________________ DOB: __________________ SSN #: _____-_____-_____

Family Member	Age	Health problems (if deceased, give age and cause of death)
Mother	____________	____
Father	____________	____
Sister(s)	____________	____
	____________	____
Brother(s)	____________	____
	____________	____
Maternal Grandmother	____________	____
Maternal Grandfather	____________	____
Paternal Grandmother	____________	____
Paternal Grandfather	____________	____

Do <u>any</u> of your blood relatives have problems involving:

Heart	________	Kidney	________	Cancer/Tumors	________
Blood Pressure	________	Liver	________	Epilepsy/Seizures	________
Lungs	________	Diabetes	________	Emotional/Psychiatric	________
Stomach	________	Stroke	________	Arthritis	________

Details: ____

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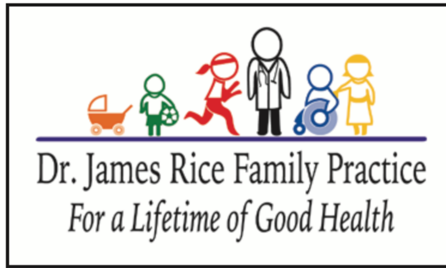

Privacy Statement

Dr. James A. Rice and staff continually strive to provide the best care possible. We want to keep you and your family healthy and active. In return, we ask for reasonable compensation for our services. Patients can sometimes accumulate a large patient-due balance, placing both parties in an unfavorable situation. If our office does not receive the compensation due, then our business suffers, and patients continue to accrue a balance. This is not acceptable. To prevent these situations from starting or continuing **co-pays and non-covered charges are due at the time of service**. Please call our office at 812-838-3730 if you have any questions regarding charges or payment options.

By signing below, I ________________________, acknowledge receipt of the Notice of Privacy Practices as required by the HIPPA regulations from Dr. James A. Rice. I give Dr. James A. Rice permission to share/release my protected health information to the following people:

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE SIGNED

Treatment for Minors Only

In the case that parent or responsible party cannot be present for appointments, the following person(s) have permission to bring __________________________________ in for medical treatment. Please list the names followed by relationship to patient.

____________________/____________________ ____________________/____________________

____________________/____________________ ____________________/____________________

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