Adult Registration Form

For Office Use Only

____/____/____

Date

Patient Information

Last Name	First	Middle	
Street Address	City	State	Zip Code
Home Phone # ( ) -	Work Phone # ( ) -	Cell Phone # ( ) -	Email Address
Date of Birth / /	Age	Social Security # - -	Marital Status ❑ Single ❑ Married ❑ Widow ❑ Divorced ❑ Separated ❑ Domestic Partnership/Civil Union
Gender ❑ M ❑ F			

Patient Employment Information

Current Employer	Occupation	How long employed	
Street Address	City	State	Zip Code
Primary Care Physician	Referred or Recommended by		

Spouse / Legal Guardian

Last Name	First	Middle	Relationship
Street Address	City	State	Zip Code
Home Phone # ( ) -	Work Phone # ( ) -	Cell Phone # ( ) -	Email Address
Date of Birth / /	Age	Social Security # - -	Employer
Occupation			
Employers Address	City	State	Zip Code

Nearest Relative (Not living at the same address)

Last Name	First	Middle	Relationship
Street Address	City	State	Zip Code
Home Phone # ( ) -	Work Phone # ( ) -	Cell Phone # ( ) -	Emergency Contact

Insurance Information

Primary Insurance	Subscriber	Primary Telephone # ( ) - Pre-Certification # ( ) -	
Street Address	City	State	Zip Code
Policy #	Group #	Employee ID / SS# / Misc	Group Name

Updates

Parent / Legal Guardians Signature: _____	Signature: _____
Date ____/____/____	Date ____/____/____

Patient Information

Name	Gender	Date of Birth	Today's Date
	❑ M ❑ F	/ /	/ /

Confidentiality

I authorize the practice to leave messages on my answering machine / voice mail: ❑ Yes ❑ No

I authorize the release of my protected health information over the telephone to the following individual(s):

Name of Person:_____ Name of Person:_____

Relationship:_____ Relationship:_____

Home#: (____) ____-____ W#: (____) ____-____ Home#: (____) ____-____ W#: (____) ____-____

For appointment reminders only:

1) Use cell phone: ❑ Yes (____) ____-____ ❑ No 2) Use e-mail: ❑ Yes_____ ❑ No

Medical History

Do you currently have, or have you had in the past (check all that apply):

❑ Cancer	❑ Depression	❑ Hearing Loss	❑ Kidney stones
❑ High blood pressure	❑ Excessive thirst	❑ Seizures	❑ Asthema
❑ Anemia	❑ High cholesterol	❑ Diabetes	❑ Persistent cough
❑ Constipation	❑ Shortness of breath	❑ Difficulty swallowing	❑ Numbness
❑ Back pain	❑ Heart disease	❑ Rectal bleeding	❑ Dizziness
❑ Weakness	❑ Headaches	❑ Thyroid disease	❑ Weight loss / weight gain
❑ Alcoholism	❑ Allergies (list):		
❑ Other:			

Social History / Habits

Do you smoke? ❑ Yes ❑ No If yes, how much a day? Have you ever smoked? ❑ Yes ❑ No If yes, when did you quit?

How much alcohol do you drink a week? Do you use illicit drugs? ❑ Yes ❑ No If yes, what kind?

Men		Women	
Have you ever had a digital rectal exam? ❑ Yes ❑ No		Age of first menstrual period?	Date of last pap test?
Have you ever had a PSA done? ❑ Yes ❑ No When?		Age when menstrual periods stopped?	Date of last mammography?
Date of last prostate exam?		Number of pregnancies?	Number of live births?

Family History

History of disease	Father	Mother	Sibling	Sibling	Sibling	Sibling	Grandparents
Diabetes	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑
Heart disease	❑	❑	❑	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑	❑	❑	❑
Thyroid disease	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑	❑
Drug/Alcohol problems	❑	❑	❑	❑	❑	❑	❑

Current Medications	**Hospitalizations**

Medication Allergies	**Safety**		
	❑ Smoke detector	❑ Family abuse	❑ Helmet
	❑ Seat belt	❑ Firearms	

Immunizations

Last Tetanus	Last Influenza	Last Pneumovax	Hepatitis B
/ /	/ /	/ /	/ /

East Michigan Medical Associates
Dr. Donald Hardman, M.D.
3499 S. Linden Rd., Suite 2, Flint, MI 48507
PH: (810) 820-8121 ● Fax: (810) 820-8335

CONSENT FOR TREATMENT / FINANCIAL AUTHORIZATION

1. I, hereby voluntarily request, consent to and authorize the physician, his/her associates, assistants or other practitioners to provide medical and minor surgical treatment, including but not limited to diagnostic procedures, x-rays, medication administration, physical examination and screening services, including drub/alcohol screening, as is deemed necessary and advisable. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examination and treatment which I have hereby authorized.

2. I authorize East Michigan Medical Associates to release to any third party payer, or its representative, including Medicare, Medicaid, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers' disability compensation insurers, employers, health maintenance organizations, preferred provider organizations and managed care plans, which may be responsible for payment in my case, or as required by law, such information from my medical record as is necessary in order to receive reimbursement for any billings rendered relating to my treatment, including alcohol and drug abuse records protected under the regulations in 42 CFR, Part 2, if any, and social services records, if any, and psychological service records including communications by me to a social worker or psychologist. I also authorize East Michigan Medical Associates to release to individuals or agencies which my provide services for my care such information from my medical record as is necessary to provide those services. I also authorize release of information to any independent auditors or reviewers retained by any third party payer, private health insurers, or any employer providing health insurance benefits to me so that these independent auditors can analyze charges.

3. I further understand that my treatment may require more than one date of service; therefore, this consent shall carry full force and effect from the date of signature until I am discharged from treatment.

4. I, hereby, assign payment directly to East Michigan Medical Associates of the insurance benefits otherwise payable to me but not to exceed the balance due to East Michigan Medical Associates for these services.

5. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill that is not paid by insurance, workers' disability compensation or social agencies.

6. I understand the content and significance of this form, and my questions have been answered.

NOTICE

If another person has a percutaneous mucous membrane or open wound exposure to my blood or other body fluids, East Michigan Medical Associates may perform, but not limited to, the following tests: an HIV, hepatitis screens, and other blood borne pathogen tests, as needed, without any additional consent. Public Act No. 488 of 1988 of the State of Michigan states that an HIV test may be performed upon me without any additional consent, if a health care professional or employee has a percutaneous, mucous membrane, open wound exposure to my blood or other body fluids.

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES.

Signature of Patient/Patient Representative Relationship Date Witness

East Michigan Medical Associates
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CONTROLLED MEDICATIONS AGREEMENT

This is an agreement between the patient and the physician, Dr. D. Hardman, M.D. and the staff concerning the prescribing of certain "controlled" medications. The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you might be prescribed. This is to assist both you and Dr. Hardman in complying with the laws associated with certain controlled substances.

I, the patient, agree to AND accept the following conditions: Please Initial After Each Statement

1. I understand that if I break this Agreement, the doctor will stop prescribing specific medications. _____
2. I will communicate fully with the doctor about the character and intensity of my pain, the effect of the pain on me daily, and how well the medicine is helping relieve the pain. _____
3. I will not seek out or use narcotics or other controlled substances from a source other than Dr. Hardman. _____
4. I will not use any illegal controlled substances, including marijuana, cocaine, etc., and agree that I will be tested for use of these substances at any time and without prior notification. _____
5. I will not share, sell or trade my medicines with anyone. I understand that it is a felony to obtain pain medication under false pretenses. This includes obtaining medications from more that one physician and/or misrepresenting myself to obtain pain medication. _____
6. I will safeguard my medicine from loss or theft. I understand that Dr. Hardman will not replace my lost, misplaced or stolen medicines. _____
7. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit because an evaluation of my condition must be made. No refills will be available during evenings or on weekends. _____
8. I agree that I will use my medicine only as prescribed and that use of my medicine at a greater rate will result in my being without medicine for a period of time. _____
9. I understand there will not be early refills on medications before they are due. _____

I agree to use _____ Pharmacy, located at _____, for filling prescriptions for all of my pain medicines.

I understand that any provisions(s) not followed in the Agreement can be grounds for discharge from care.

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding this treatment have been adequately answered.

This Agreement is entered into on this _____ day of _____, _____

Patient: _____ Physician:_____

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Dear Patient,

This is your notification that as of this date you are required to bring all controlled prescription medication bottles to all future appointments. This is to ensure that your medications are being taken correctly as prescribed. At the direction of a physician, the medical support staff may or may not conduct a pill count of your medications. If you fail to bring the medication bottles or the pill count is inaccurate, no further prescriptions will be given and any remaining refills will be cancelled.

The medications must be in the original container as dispensed by your pharmacy with the label unmarked. Substitution of another medication into your bottle will result in no further controlled substances being prescribed.

Additionally, a urine test may be conducted during your visit. Any irregularity of the test sample or results will result in a discontinuation of prescriptions for any controlled medications.

Both the pill count and urine test shall be conducted in accordance with Food and Drug Administration (FDA) and Drug Enforcement Agency (DEA) guidelines.

We apologize for any inconvenience and thank your for your cooperation.

Sincerely,

Donald J. Hardman, M.D.

Patient Agreement

Please write the following to show your agreement:

"I have read and understand that I am required to bring my **controlled prescription bottles** to each office visit."

Name (Print) Date Signature Staff Initials