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JEFFERERSON FAMILY MEDICINE NEW PATIENT REGISTRATION FORM

Incomplete or illegible forms may be returned and will delay enrollment

Full Name: _____ Sex: ____ DOB:_____ SSN:_____

Address: _____ City, State, Zip:_____

Home Phone: _____ Cell phone: _____

Email:_____ *Please ask about our patient portal*

Spouse Name: _____ Spouse Cell Phone: _____

Emergency Contact Name:_____ Phone:_____ Relation:_____

Primary Insurance Carrier: _____ Subscriber ID:_____

Secondary Insurance Carrier: _____ Subscriber ID:_____

Preferred Language:_____

Pharmacy Name:_____ Pharmacy Address:_____

All patients under 18 complete:

Mother Name: _____ *Address:* _____ *Phone:*_____

Father Name: _____ *Address:* _____ *Phone:* _____

*Non-Parental Legal Guardian Name (if not living with parents):*_____

Optional Demographics:
Race:_____ Ethnicity: Hispanic or Non-Hispanic Sexual Orientation:_____ Gender Identity:_____

No-Show Policy: If you miss an appointment or cancel your appointment within (24) hours of your appointment time you will be billed a $25.00 no-show fee. Additionally, two no-shows or cancelations with less than (24) hour notice will be grounds for dismissal from the practice.	Initial
Controlled Medication Policy: Jefferson Family Medicine will not prescribe controlled substances for non-cancer chronic pain.	Initial
Copay-Deductible Policy: If your insurance requires a co-payment, it is expected at check-in. If your insurance plan has a deductible you will be expected to make a down-payment of $75 before you will be seen. The balance will be billed. If the provider agrees to see you without your payment a $10 billing fee will be imposed.	Initial
Vaccine Policy: Jefferson Family Medicine believes in the safety and effectiveness of our vaccines and requires all children and young adults to receive all recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.	Initial

HIV Test Consent: Your health care provider is required to present an offer of HIV testing to all persons aged 13-64 years old regardless of apparent risk. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important information about your health and give you what you need to make good decisions for staying healthy and give you what you need to make good decisions for staying healthy.

Please initial one: *I accept the offer of HIV testing* _____ *I do not want an HIV test today*_____

Laboratory Testing Policy: In addition to a number of other labs such as cholesterol, blood sugar and blood count, your health care provider routinely performs a urine toxicology (drug) screen on all new patients as part of the comprehensive care we provide.

Please initial one: *I accept the screen* _____ *No, I decline the screen*_____

I attest that the above information is correct and I have read and understand the aforementioned policies.

Patient Signature:_____ Date: _____