

**MED CENTER
PATIENT REGISTRATION FORM**

Patient Information:

Last Name:	First	MI	M/F	Birthdate:	SS#:
Home address:	City	State/Zip	Home phone:		
Employer:				Work phone:	
Employer address:	City	State/Zip			

PRIVATE PAY
 INSURANCE
 MEDICARE

Insurance Information:

Insurance Company:	ID#:	
Insurance address:	Group #:	
Name of Insured:	Insured's Employer	Relationship to Patient:
Secondary Insurance:	ID#	
Secondary Insurance address:	Group #:	
Name of Secondary Insured:	Secondary Insured's Employer:	Relationship to Patient:

Emergency Information:

Emergency Contact:	Relationship to Patient:	Phone:
Alternate Contact:	Relationship to Patient:	Phone:

Assignment of Benefits:

I hereby authorize release of information necessary to process my claims and assign benefits otherwise payable to me, to the MED CENTER. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature _____

Date _____

Notice of Privacy Practices Received

Sign _____

Date _____

PERSONAL MEDICAL HISTORY

<input checked="" type="checkbox"/>	Check All That Apply to YOU	Explanation/Comments
	Heart Disease	
	Asthma/Lung Disease	
	High Blood Pressure	
	Diabetes	
	High Cholesterol	
	Thyroid Problem	
	Kidney Disease	
	Cancer	
	Genetic Disorder	
	Depression/Anxiety/Mental Disorder	
	Other:	
	Past Surgeries (Please list):	

Family Health History

Please indicate the current status of your IMMEDIATE FAMILY MEMBERS. Indicate which family member (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Condition	Family Member(s)	Status <small>(Living, Deceased, Currently being treated)</small>
Cancer		
Heart Disease		
Depression/Suicide		
Genetic Disorders		
Diabetes		
High Cholesterol		
High Blood Pressure		
Stroke		
Bleeding/ Clotting Disorder		
Asthma/COPD		
Other:		

SOCIAL HISTORY

<p style="text-align: center;">Tobacco Use</p> <p>Cigarettes: <input type="checkbox"/> Never <input type="checkbox"/> Quit Date _____</p> <p><input type="checkbox"/> Current Smoker: Packs per Day _____ # of Years _____</p> <p>Other Tobacco: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew</p>	<p style="text-align: center;">Home Life</p> <p><input type="checkbox"/> Single <input type="checkbox"/> Partnered/Married <input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed <input type="checkbox"/> Other _____</p> <p>Who lives at home with you? _____</p>
<p style="text-align: center;">Alcohol Use</p> <p>Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes # of Drinks per Week _____</p>	<p style="text-align: center;">Caffeine Intake</p> <p><input type="checkbox"/> None <input type="checkbox"/> Coffee/Tea/Soda _____ cups per day</p>
<p style="text-align: center;">Drug Use</p> <p>Do you use any recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If Yes, what type(s)? _____</p>	<p style="text-align: center;">Other</p> <p>What type of work do you do? _____</p> <p>Is there anything else we should know about?</p>

MED CENTER MEDICAL CLINIC

6651 MADISON AVENUE
CARMICHAEL, CA 95608

TELEPHONE (916) 965-1111
FAX (916) 965-5143

CANCELLATION AND NO-SHOW POLICY

This notice is to inform you of Med Center's *Cancellation and No-show Policy*.

If you do not show up for your scheduled appointment AND if you did not cancel your appointment at least 48 hours (two full days) in advance, Med Center Medical Clinic will charge you a \$50 no-show fee. The no-show fee is a separate charge that will not be covered by your insurance plan. You will be responsible for this fee in which the charges will need to be paid in full before we will schedule any further appointments.

The amount of the fee will depend on the nature of your scheduled visit. Missed follow-up appointments and cancellations less than 48 hours prior to your visit will result in Med Center implementing the \$50 fee. For missed procedures, tests, special appointments, or double-booked appointments will result in a fee of \$100 or more.

BEFORE CHARGING YOU A NO-SHOW FEE, MED CENTER MEDICAL CLINIC WILL CONSIDER EXTENUATING CIRCUMSTANCES ON A CASE-BY-CASE BASIS.

Why do we charge a no-show fee? Any missed appointments that are not cancelled in advance (48 hours) affects staff's time and amount of care in which we could offer to other patients who are in need. Each no-show visit represents a missed opportunity for another Med Center patient to see a provider. In addition, certain supplies and medications that we have ordered for your appointment may be at a loss if you do not attend your visit.

By signing, you are fully aware and understand Med Center Medical Clinic's no-show policy. Failure to comply will result in the implementation of the fees explained above.

Patient's Name (PRINT):

Patient's Signature/Guardian:

Date:



Dear Patient,

All or part of your clinical laboratory testing will be performed by Quest Diagnostics. The main office is located at 6511 Golden Gate Drive, Dublin, California 94568. Quest Diagnostics will bill you for the laboratory tests ordered today. Should you carry insurance, they will, as a courtesy, send a claim to your insurance if you provide the information today on this sheet. Please note that if the laboratory receives insufficient information with which to submit a claim to your insurance, they will bill you directly. You will be responsible for the cost of today's laboratory tests. If you do not carry insurance, Quest Diagnostics, will send you a bill 5-10 days after the test results are received. They expect payment by you within 20 days after receipt of the statement. Should you have any questions about your bill, please contact them directly Monday-Friday 9:00am-5:00pm at 1-800-326-4756.

All patients please complete this section:

Patient Name: _____

Mailing Address: _____
Street City Zip Code

Insured patients please complete this section if you wish your insurance billed:

Insured/ Employee Name: _____

Relationship to Patient: _____

Insured's Employer Name: _____

Insurance Company Name: _____

Address of Insurance Company Claim Department _____

Subscriber ID# _____ Group # _____ Policy # _____

I hereby authorize payment directly to Quest Diagnostics of medical benefits otherwise payable to me. I understand that I am financially responsible for the fees not covered by this authorization.

Signature

Date