REGISTRATION

ATLANTIC FAMILY PHYSICIANS

2 LEE AVE. UNIT 103
GEORGETOWN DE 19947
PHONE 302-856-4092
FAX 302-856-4153

PATIENT INFORMATION

NAME:_____ SOCIAL SECURITY#_____-_____-_____
LAST FIRST MI

ADDRESS_____ CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____ AGE_____ HOME #_____ CELL_____ DRIVERS LICENSE#_____

PLEASE CIRCLE

GENDER: Male / Female

MARTIAL STATUS: Single / Married / Widowed / Separated / Divorced

RACE: African American / Arabic / Asian / Vietnamese / Caucasian / Hispanic Other: _____

LANGUAGE: Arabic / English / Russian / Spanish / Vietnamese / Other: _____

Patient Employed by: _____ Occupation: _____

Business Address:_____ City:_____ State:_____ Zip:_____

Business Phone: _____ Email Address: _____

In case of Emergency
Who should be notified? _____ Relationship to patient: _____ Phone#:_____

Pharmacy: Name:_____ Address_____ Phone_____

PRIMARY INSURANCE

Person Responsible for Account:_____

Relationship to Patient:_____ Date of Birth:_____ Social Security #_____

Address (if different from patient)_____ City_____ State _____ Zip _____

Person Responsible
Employed By: _____ Occupation_____ Diver License #_____

Business Address _____ City_____ State _____ Zip _____

Name of Dependants
Business Phone#_____ Covered under this plan: _____

Insurance Company_____ Subscriber ID#_____ Group#_____

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? Yes OR NO Subscribers Name: _____

Address (If different from patient)_____ City_____ State_____ Zip_____

Date of Birth_____ Relationship to Patient_____ Drivers License#_____

Subscribers Phone#_____ Subscribers Employer_____ Occupation_____

Employers Address_____ City_____ State_____ Zip_____

Insurance Company_____ Social Security #: _____

Subscriber ID# _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I(or my dependent) have Insurance coverage with _____ and assign directly to Atlantic Family Physicians all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all Insurance submissions.

Responsible Party Signature:_____ Relationship_____ Date:_____

MEDICAL HISTORY INFORMATION

Name:			Date:	
Sex:	DOB:	Age:	Ht:	Wt:
Known Drug Allergies:				
Date of Last Physical:		Last Menstrual Period:		
Surgeries:				
Date of Last Pap:	Date of Last Mammogram:		Number of Pregnancies:	
Have you ever had any chronic problems with?				

	Yes	No	Explanation:
Eyes			
Ears			
Headaches			
Nose			
Throat			
Chest			
Breathing			
Heart			
Lungs			
Stomach			
Food Digestion			
Intestines			
Rectum			
Constipation			
Diarrhea			
Bladder			
Kidneys			
Urination			
Ovaries			
Uterus			
Cervix			
Menstruation			
Blood Disorder			
Immune Deficiency Disorder			
Testicle/ Penis			
Sexually Transmitted Disease			
Skin			
Legs/Arm			
Depression			
Emotional Problems			
Sleep Problems			
Personal/Work Stress			

Atlantic Family Physicians
2 Lee Ave Unit 103
Georgetown, DE 19947
(Phone) 302-856-4092 (Fax) 302-856-4153

Social History

Please indicate family history
Please circle all that apply:

Illness/ Condition	Family Member						Describe:
Cancer:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Ulcers:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Diabetes:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Heart Disease:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Prostate:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
High Blood Pressure:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
HIV:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Breast:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Heart Attack:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Gallbadder Disease:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Stroke:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Migraines:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
TB:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Blood Disease:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Mental Illness:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Thyroid	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Seizures:	Mother	Father	Sister	Brother	Grandmother	Grandfather	
Asthma:	Mother	Father	Sister	Brother	Grandmother	Grandfather	

Do you Smoke?: Yes Or No # of cigarettes a day: _____

Do you Drink?: Yes Or No # of drinks a day:_____ # of drinks a week: _____

Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

Medication List

Please include prescription medication name, your dosage and prescribing doctor. Include **ALL** over over-the-counter medications, herbs, and vitamins.

Medication Name	Dosage	Prescribing Doctor

Please list all doctors/ specialist that you see

Name of **prior** primary care physician: _____

Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, [patient name]_____, acknowledge and agree that I have reviewed a copy of Atlantic Family Physicians Notice of Privacy Practices, I agree a photocopy of this document is valid.

_____ _____
Patient Signature Date

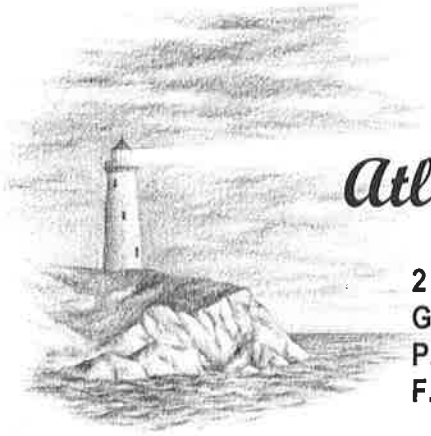
_____ _____
Signature of Patients Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

Office Use Only:
Atlantic Family Physicians made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: Identify the efforts that were made to obtain the individuals written acknowledgement, including the reasons if known why the written acknowledgement was not obtained.

_____ _____
Signature of Employee Date

_____ _____
Print Name of Employee Title



Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

Cancellation Policy/No Show Policy for Doctor Appointments

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If you are 15 minutes past your scheduled time we will have to reschedule the appointment.

_____

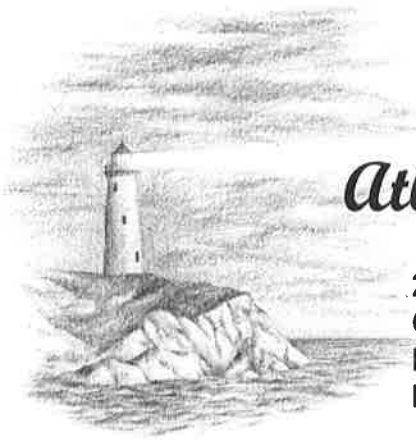
Print Name Patient

_____

Signature Patient/Guardian

____/_____/_____

Date



Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

ACKNOWLEDGEMENT

I acknowledgement that I have read a copy of the Atlantic Family Physicians Office and Financial Policies, I understand that if I wish to have a copy the office staff will provide me with a copy upon my request.

_____ _____

Signature/Parent or Guardian Date

Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

PATIENT PORTAL CONSENT FORM

Atlantic Family Physicians offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose same conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

The Link to access the Patient Portal is: ClickMyDoctor.com

How the Secure Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons form reading communications, Information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the web site and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you keep track of who has access to your email account so that only you, or some you authorize, can see the messages you receive from us. If you pick up secure messages from a website, you need to keep unauthorized individuals form learning your password. If you think someone has learned your password, you should promptly go the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedure Regarding the Patient Portal that appears at log in. I understand the risks associated with the online communications between my Atlantic Family Physicians and me, and consent to the conditions outlines herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen as well as the other Instructions that my physician may Impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

I have read and understand the use of the Patient Portal:

- I understand that the Patient Portal will allow me the opportunity to:
  - Update my demographic/ medical information
  - Review my labs, diagnostic tests, and office visit summary
  - Request appointments, referrals and refills
- I understand that this site will not be used to ask medical advice or questions regarding my care.
- I understand it is my responsibility to make a follow up appointment 7-10 days following my test, with my medical provider to discuss results.
- I understand that the Patient Portal may not publish all labs and diagnostic testing pertaining to my care.

Print Name_____ _____/_____/_____

Last First Middle Initial Date of Birth

Cell Phone_____ Email_____

Confirm

Signature: _____ Email: _____

Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

Controlled substance agreement

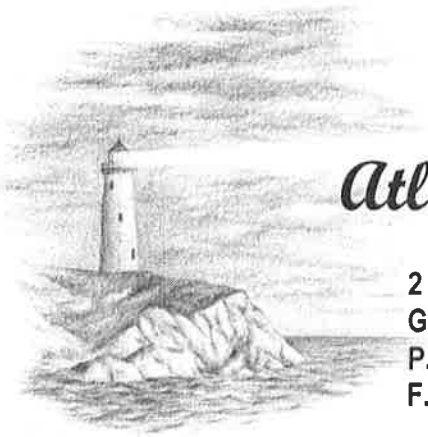
We are committed to doing all we can to treat your chronic pain condition, anxiety, depression, attention deficit, and chronic insomnia. In some cases, controlled substances are used as a therapeutic option in the management of these conditions, which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the medical provider by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I," "you," "me," or "my" refer to you, the patient. The term medical provider refers to a "physician", "Advanced Practice Registered Nurse" or "physician assistant".

1. All controlled substances must come from the medical provider whose signature appears below or, during his/her absence, by the covering medical provider, unless specific authorization is obtained for an exception. I understand that I must tell the medical provider whose signature appears below or, during his/her absence, the covering medical provider, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each medical provider knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:
Pharmacy: _____ Phone: _____
3. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required.
Presence of unauthorized controlled or illegal substances in urine or serum toxicology screens may result in your discharge from this facility.
5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the medical providers whose signature appears below or, during his/her absence by the covering medical provider, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
8. in the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this medical provider and other medical provider at the facility and that law enforcement officials may be contacted.
10. I affirm that I have full right and power to sign and be bound by this agreement and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

PATIENT'S FULL NAME: _____

PATIENT'S SIGNATURE DATE: _____

PHYSICIAN'S SIGNATURE DATE: _____



Atlantic Family Physicians

2 LEE AVE UNIT 103
GEORGETOWN, DE 19947
P. (302)856-4092
F. (302)856-4153

Attention

Are you seeing a Pain Management Specialist?

☐ **Yes** ☐ **No**

Patient Name: _____ **DOB:** ___/___/___

Patient Signature: _____

Date: _____/_____/_____