PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY)

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

Social Security No. _____ - _____ - _____ Gender: _____

Date of Birth: _____/_____/_____ Marital Status: _____

Employment/School Status (circle one): Full Time Part Time On-Call Retired

Employer/School: _____

Address: _____

Job Title: _____ Employed Since: _____/_____/_____

In Case of Emergency, Please Notify:

Name: _____ Relationship: _____

Home Phone: _____ Work/Cell Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Work/Cell Phone: _____

I hereby authorize the performance of all examinations, diagnostic testing, procedures and treatments which maybe necessary or desirable for my medical care. I realize that I am responsible for any office visit costs, insurance deductibles, office co-pays, and/or non-covered services (where applicable).

Patient Signature: _____ Date: _____

Staff/Witness Initials: _____

MEDICAL HISTORY FORM

PLEASE PRINT Date: _____

Patient Name: _____ DOB: _____
Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Other Phone: _____
Driver's License Number: _____ Social Security Number: _____
Sex (Circle): Male ☐ Female ☐

Do you have allergies to medications, X-Ray dyes, or other substances? ☐ Yes ☐ No
If yes, please list the name of the substance and type of reactions below.

Medication or Substance	Type of Reaction

Past Medical History & Review of Systems
Please circle if you have had problems with or are currently experiencing any of the following:

1. High Blood Pressure	13. Alzheimer's Dementia	25. Pancreatitis	37. Chronic Back Pain
2. Heart Failure	14. Multiple Sclerosis	26. Gallstones	38. Cancer
3. High Cholesterol	15. Migraine Headaches	27. Hemorrhoids	39. Skin Diseases
4. Heart Disease/Heart Attack	16. Asthma	28. Cystitis	41. Blood Disorders
5. Atrial Fibrillation	17. COPD	29. Prostate Problems	42. Venereal Diseases
6. Poor Circulation	18. Diabetes	30. Kidney Stones	43. Anxiety
7. Aneurysm	19. Irritable Bowel Syndrome	31. Blood in urine	44. Depression
8. Stroke	20. Crohn's Disease	32. Kidney Disease	45. Anemia
9. Carotid Artery Disease	21. Ulcerative Colitis	33. Thyroid Disorder	46. Alcohol Abuse
10. Seizures	22. GERD/Heartburn	34. Arthritis	47. Drug Abuse
11. Neuropathy	23. Hepatitis	35. Osteoporosis	48. Tobacco Abuse
12. Parkinson's Disease	24. Ulcers	36. Fibromyalgia	49. Other

Gynecologic and Obstetric History:
Age at onset of period: _____ Frequency: _____ Length of Period: _____
Pregnancies: _____ Births: _____ Miscarriages: _____
Prolonged or abnormal bleeding: ☐ Yes ☐ No If yes, please explain: _____
Leakage of urine: ☐ Yes ☐ No If yes, please explain: _____
Pelvic Pain: ☐ Yes ☐ No If yes, please explain: _____
Abnormal discharge: ☐ Yes ☐ No If yes, please explain: _____

Please List and Supply Dates of:
Surgeries: _____
Hospitalizations other than for surgery: _____

Immunization History:
Hepatitis B ☐ No ☐ Yes When: _____ Pneumovax ☐ No ☐ Yes When: _____
Tetanus ☐ No ☐ Yes When: _____ Influenza ☐ No ☐ Yes When: _____
Shingles: ☐ No ☐ Yes When: _____ Prevnar-13 ☐ No ☐ Yes When: _____

When was your last:
Pap Smear: _____ Diabetes Screen: _____ Colonoscopy: _____
Mammogram: _____ Cholesterol Check: _____ Prostate Exam: _____

PLEASE PRINT

Patient Name: _____ DOB: _____

Family History: Please indicate if any member of your family (including parents, grandparents, and siblings) ever had any of the following:

Illness	Which family members?	Approx. Age When Diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Stroke		
Mental Illness (depression, anxiety)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dosage	Drug Name	Dosage
1		6	
2		7	
3		8	
4		9	
5		10	

Prevention and Other Information:

Do you wear seatbelts?	☐ Yes	☐ No	If no, why not?
Do you wear a bike helmet?	☐ Yes	☐ No	☐ Not Applicable
Do you smoke?	☐ Yes	☐ No	If yes, how many packs per day?
Do you drink alcoholic beverages?	☐ Yes	☐ No	If yes, how much per week?
Do you drink coffee?	☐ Yes	☐ No	If yes, how many cups per day?
Do you drink tea?	☐ Yes	☐ No	If yes, how many cups per day?
Do you use drugs? (Opiates, cocaine, etc.)	☐ Yes	☐ No	If yes, explain:
Have you ever engaged in any activity that has put you at risk of getting AIDS?	☐ Yes	☐ No	☐ I'm not sure. If yes, please explain:
Do you wish to be tested for AIDS?	☐ Yes	☐ No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	☐ Yes	☐ No	☐ I'm not sure. If yes, please explain:
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised, forced to have sex) by your partner?	☐ Yes	☐ No	
Do you ever feel afraid of your partner?	☐ Yes	☐ No	
Do you have a living will?	☐ Yes	☐ No	
Do you have an organ donor card?	☐ Yes	☐ No	

Branton & Jarrah, P.A.

1205 Pemberton Dr. Ste 101
Salisbury, MD 21801
www.the-med-spa.com
www.bjpa.net

This form allows our office to release medical information to anyone listed below. We will not release any medical information to spouse, family, friends, etc., without prior authorization from the patient.

DATE: _____

THIS AUTHORIZES BRANTON & JARRAH, P.A. TO RELEASE INFORMATION REGARDING MY MEDICAL FINDING, MY FINANCIAL RECORDS OR ANY INFORMATION PERTIENT TO MY MEDICAL CONDITION TO:

NAME	RELATIONSHIP	PHONE

_____
PATIENT OR GUARDIAN SIGNATURE

_____
WITNESS SIGNATURE

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Appointment Reminders

Patient Acknowledgement and agreement to Text and/or E-Mail Communication

I have discussed with Drs. Branton & Jarrah or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of text and/or e-mail between Drs. Branton & Jarrah and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Drs. Branton & Jarrah may impose to communicate with patients by text and/or e-mail. Any questions or concerns I may have had were answered.

Please indicate which way you prefer to be reminded of your next appointment.

Home/Work Phone: _____

Cell: _____

Text: _____

E-Mail: _____

_____ _____

Patient Signature Date

_____

Staff Initials

Branton & Jarrah, P.A.

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FINANCIAL RESPONSIBILITY STATEMENT

(Signing this document will affect your rights under Maryland law. Please read carefully before signing this document.)

I, _____, (patient name) am seeking medical attention from Drs. Branton and Jarrah, PA (the practice)

I understand the practice is Fee-For-Service and I am required to pay the balance in full at the time of visit. The practice will submit charges on my behalf to my insurance carrier. The practice is not responsible for reimbursement from my insurance carrier. I understand, reimbursement, if any, will be based on my insurer's fee schedule and if the service is a covered necessity. In the case of HMO, I understand that I may not be entitled to reimbursement.

Appointments: Once an appointment is made, please remember this time has been reserved for you. A minimum charge will be made for failed or cancelled appointments without prior notification preferably within 24 hours. This fee covers only a portion of the overhead such as salaries, electricity, heat, rent, etc., which still has to be paid whether you are present or not.

_____ _____

(Patient Signature) (Date)

Branton & Jarrah, P.A.

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PATIENT CONSENT FORM

By signing this form you are granting consent to **Branton & Jarrah, P.A.** at the address above to use and disclose your protected health information (PHI) for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we use this protected health information (PHI). You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Drs. Branton & Jarrah, P.A. have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc (CRISP) a regional health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org.

Your have the right to request to restrict how we disclose your protected health information (PHI) for the purposed of treatment, payment, and health care operations. We are not required by law to grant your request. However, if we grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we have already used your protected health information (PHI) in reliance on your consent.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from our business office.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

Drs. Branton & Jarrah, PA

LATE CANCELLATION & REFERRAL POLICIES

LATE CANCELLATION POLICY:
We understand that an emergency may occur and may result in you missing your appointment or having to cancel an appointment. If such an emergency happens, we will be glad to reschedule your appointment. However, if you fail to arrive for a scheduled appointment or if you cancel an appointment with less than 24 hours' notice, you will be charged a $40.00 no-show/cancellation fee.

REFERRAL POLICIES:
If you require a referral to see a specialist, we require 48 hours' notice to complete the referral (except for life-threatening emergencies).

I have received a copy of the Late Cancellation and Referral Policies and I understand that if I fail to show up for an appointment or cancel an appointment with less than 24 hours' notice, I will be charged $40.00.

Name of Patient: (Please Print) _____

Signature of Patient: _____

Date: _____

Copy Provided by: (staff initials) _____

OR

Name of Patient's Representative: (Please Print) _____

Signature of Patient's Representative: _____

Relationship of Representative to Patient: _____

Date: _____

3/5/08

Drs. Branton & Jarrah, PA. 1205 Pemberton Drive, Ste:101. Salisbury, MD 21801
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