Menla Healthcare
Patient Registration Form

Patient Information

Today's Date ____/____/____ What do you prefer to be called? ______________________________

Legal Last Name ______________________ Legal First Name ______________________ MI _______ DOB ____/____/____

Address ______________________________________ City ______________________ State _____ Zip _______________

Home # ______________________ Cell # ______________________ Work # ______________________ Ext __________

Social Security # _______ - _____ - _______ ☐ M ☐ F / ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Health Insurance Information

Primary Insurance Name ___________________________

Group/Plan # ____________________________________

Policy/Member # _________________________________

Insured's name __________________________________

Insured's DOB ____/____/____

Insured's SS# _______ - _____ - _______

Insured's Employer _______________________________

Relationship to patient ____________________________

Co-pay $ __________

Customer Service Phone # __________________________

Referral Required? ☐Yes ☐ No

Secondary Insurance Name _________________________

Group/Plan # ____________________________________

Policy/Member # _________________________________

Insured's name __________________________________

Insured's DOB ____/____/____

Insured's SS# _______ - _____ - _______

Insured's Employer _______________________________

Relationship to patient ____________________________

Co-pay $ __________

Customer Service Phone # __________________________

Referral Required? ☐Yes ☐ No

Emergency Contact Information

Emergency Contact Name________________________________ Relationship to Patient _________________________

Contact Information ____

How did you hear about us? ☐ **Referred by:** _______________________ ☐ **Newspaper:** ***specify*** ____________________ ☐ **Brochure** ☐ **Website:** **www.menlahealthcare.com** ☐ **Other** ____

Full payment is due at the time of service unless you are covered by an accepted commercial insurance or governmental coverage plan. We participate in a variety of insurance companies, however, the person who is financially responsible, is *personally* liable for all balance not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining. Overdue accounts will be referred to a collection attorney. Legal fees that we pay to secure past due balances will be added to your account. Payments for co-pays are expected at time of service. For checks returned to us as unpaid by your bank, we will charge a $25.00 fee. Please contact our Billing Office if you have any questions or concerns at 609.688.1608.

I have read the Financial Policy above. I understand and agree to the Financial Policy. You have authorization to charge my credit card for any current or past due personal balance(s) upon receiving my verbal or written permission.

Signature of Patient/Guardian ____ **Date** ____/____/____

Menla Healthcare

Confidential Health History Questionnaire

Name (Last, First, M.I.) ____ ☐ M ☐ F

Marital Status: ☐ Single ☐ Partnered ☐Married ☐ Separated ☐ Divorced ☐ Widowed

Personal Health History

Childhood Illnesses: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic ☐ Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed and date of onset:

Allergies (list allergies to medicines or other substances)

Surgery/Hospital Visits

Year	Reason	Hospital

Medications (list all medications you take regularly - prescription and non prescription)

Drug Name	Strength	Frequency Taken

Health Habits and Personal Safety

Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes - pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		

Exercise	☐ Sedentary (no exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf
	☐ Occasional Vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min)
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 mins)

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy, list contraceptive or barrier method used:		
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

Family Health History

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Sibling**	☐ M ☐ F	
Mother			**Children**	☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	

Women Only

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breast-feeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Date of last pap?		

Men Only

Do you usually get up to urinate during the night? If yes, # of times _____	☐ Yes	☐ No
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from your penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

Signature of Patient/Guardian ____ Date ____/____/____

Menla Healthcare

NOTICE OF PRIVACY PRACTICES

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to Menla Healthcare LLC.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review Practitioner's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient/Guardian ______________________________ Date ____/____/____

I give permission for Menla Healthcare to communicate my health information (e.g. Lab results) in the ways checked below:

☐ **Home Phone** ____________________________ ☐ **Address** ________________________________

☐ **Cell Phone** ____________________________ ________________________________

☐ **Work Phone** ____________________________ ☐ **Other** ________________________________

☐ **I give permission for Menla Healthcare to leave messages on the phone number(s) listed above:**

People We May Talk With About Your Medical Care	
Name	**Relation**

Signature of Patient/Guardian ______________________________ Date ____/____/____

Menla Healthcare, LLC

Mission Statement

Menla Healthcare LLC provides complete and compassionate medical care for the entire family in a professional and nurturing environment. We strive to maintain availability for our patients and to act as advocates for those in need.

APPOINTMENT RESCHEDULING, CANCELLATIONS & NO SHOW POLICY

In order to uphold our promise to be available to our patients, if you need to reschedule or cancel your appointment, we ask that you give us at least 24 hours notice. If an appointment is missed without notification, we consider it a "No-Show". After three no-shows within any 6-month period, you will be charged $25 for subsequent no-shows. This fee is ***not*** a No-Show Charge, rather it is an administrative fee for the time it takes to process your chart and follow up on no-show(s). Thereafter we will accommodate your needs on a same-day basis.

I have read, understand and agree to the appointment rescheduling/cancellation policy above.

Signature of Patient/Guardian ____ Date ____/____/____