CATON FAMILY PHYSICIAN CARE, PC
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www.catonfamilyphysiciancare.com

DELMY Y. CATON, M.D.

PATIENT REGISTRATION SHEET

PATIENT INFO

FIRST _____ MI __ LAST _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PH _____ WORK PH _____
CELL PH _____ DOB _____
GENDER M ☐ F ☐ SSN _____
EMAIL ADDRESS _____
PRIMARY LANGUAGE _____
HISPANIC Y ☐ N ☐ RACE _____
MARITAL STATUS M ☐ S ☐ D ☐ W ☐
EMPLOYER'S NAME _____
EMPLOYER'S ADDRESS _____
CITY _____ STATE _____ ZIP _____
NAME OF EMERGENCY CONTACT NOT SAME ADDRESS
NAME _____
RELATIONSHIP _____ PHONE _____

PRIMARY INSURANCE INFO – POLICY HOLDER

FIRST _____ MI __ LAST _____
RELATIONSHIP TO PATIENT _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PH _____ WORK PH _____
EMPLOYER'S NAME _____
EMPLOYER'S ADDRESS _____
CITY _____ STATE _____ ZIP _____
SSN _____ DOB _____
GENDER M ☐ F ☐
MARITAL STATUS M ☐ S ☐ D ☐ W ☐
NAME OF PERSON RESPONSIBLE FOR PAYMENT
FIRST _____ MI __ LAST _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO _____
ADDRESS _____
POLIC Y/CONTRACT # _____
GROUP NUMBER _____
NAME OF POLICY HOLDER _____

SECONDARY INSURANCE CO _____
ADDRESS _____
POLICY/CONTRACT# _____
GROUP NUMBER _____
NAME OF POLICY HOLDER _____

ASSIGNMENTS OF BENEFITS AND/OR GUARANTEE OF ACCOUNT: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO CATON FAMILY PHYSICIAN CARE FOR THE BENEFITS PAYABLE UNDER THE TERMS OF MY POLICY FOR MY ILLNESS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE INCLUDING ALL COST OF COLLECTION AND REASONABLE ATTORNEY'S FEES.

DATE __/__/____ SIGNATURE _____

PAYMENT IS DUE AT TIME OF SERVICE

YOUR RIGHT TO PRIVACY

We at Caton Family Physician Care respect your right to privacy. Therefore, our physicians and staff will only access and use your PHI (Protected Health Information) for the following TPO (Treatment, Payment, and Healthcare Operations):

1. *To provide your care here in our office*
2. *To collect payment from your insurance company*
3. *To assist your pharmacy in filling your prescriptions*
4. *To coordinate your care with your other physicians, past or present. It is important that your care be coordinated with all of your doctors*
5. *When a minor reaches the age of fourteen, we can no longer discuss the child's private medical information with a parent without the child present or written consent from the child. The exception is as follows: if a minor seeks medical treatment and wishes to use the parent's insurance policy, it is the policy holder's right to know what their insurance company has been billed for. If the minor does not wish for the policy holder to be given that information, they must pay cash at the time of service.*

****All other releases of your PHI (Protected Health Information) will only be with your permissions, authorized with a signature from you. THIS INCLUDES YOUR IMMEDIATE FAMILY UNLESS OTHERWISE DESIGNATED BELOW!! In the event of an emergency, we will contact your designated emergency contact.*

****You have the right to review or request copies of your records at any time. We request that you give us 48 hours notice in order to accommodate your request.*

I give permission for information to be left on my answering machine/voicemail at the following number:

_____.

I authorize the staff of Caton Family Physician Care to discuss my care with the following people:

*Name*_____ *Phone number*_____

*Name*_____ *Phone number*_____.

I understand and consent to the use of my PHI (Protected Health Information) for the above purposes.

*Signature*_____ *Date*_____

CATON FAMILY PHYSICIAN CARE, PC
INFORMATION AND POLICIES

In order to make your transition to our practice as simple as possible, below are some policies that you will need to read and sign. We look forward to serving you as our patient.

1. *Office hours are from 8:00 am to 5:00 pm Monday through Thursday & 8:00 am to 12:00 pm on Fridays. During the week we will be available to you 24 hours a day. After hours calls are for emergencies only. In the event of an emergency, call our office number and our answering service will contact the physician on call.*

Initial:___

2. *Controlled Substances: Because we do not provide care for chronic pain management with controlled substances, such as narcotics, any chronic pain needs or other medical conditions requiring long-term controlled substances will be referred to chronic pain management who can offer the best care for you.*

Initial:___

3. *PRESCRIPTION REQUESTS REQUIRE 24 HOUR NOTICE. Antibiotics will not be called in under any circumstances without first seeing the doctor. Any routine medication refills will be called in during regular office hours only so that we can have your medical record available. Please bring all of your medications to your visits & request refills at that time.*

Initial:___

4. *We prefer good quality preventive medicine to emergency only care. This is better medical care for you and your family. Please make an effort to establish with your caregiver a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date standards for good health care for you. We also prefer to see you in the office instead of providing care via telephone.*

Initial:___

5. *YOUR INSURANCE WILL BE FILED FOR YOU AS A COURTESY. Please be familiar with the terms and policies of your insurance plan. If you have a deductible, which has not been met, or your insurance deems your visit as a non-covered service (even with Blue Cross), you will be responsible for the balance. THE TERMS OF YOUR INSURANCE POLICY ARE BETWEEN YOU AND YOUR INSURANCE COMPANY. All copayments are due at the time of service. Collections fees will be charged if your account is turned over to our collection agency. In the case of divorced parents, the primary care giver will be responsible for any copayments or balances covered by insurance unless legal documentation is provided showing otherwise.*

Initial:___

6. *There will be a $20.00 charge on all returned checks. IF YOU MISS AN APPOINTMENT WITHOUT NOTIFYING THE OFFICE STAFF AT LEAST ONE HOUR PRIOR TO YOUR APPOINTMENT, A $25.00 FEE WILL BE CHARGED TO YOUR ACCOUNT If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule in order to be fair to the other patients who arrive on time. In the same regard, we make our best effort to see our patients at the time of their appointment, but in the event of an unforeseen medical situation, please understand that if we are running behind, you will receive your physician's best care as soon as possible. We appreciate your patience.*

Initial:___

7. *ALL PATIENTS WILL NEED TO BRING A CURRENT DRIVERS LICENS OR PHOTO ID AND AN UPDATED INSURANCE CARD. If you do not bring your updated insurance card you will be expected to pay in full.*

Initial:___

8. *Health Forms: We understand that health forms are required by many agencies, and we will be happy to fill these out during your appointment free of charge if it does not delay the care of other patients. Lengthy forms may have to be completed and picked up later. Any form completion requested outside of an office visit will be subject to a $25.00 charge as well as a $1.00 mailing charge.*

Initial:___

9. *Dismissal: We sincerely hope that we never have to part ways with a patient. However, some extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have 30 days to find another doctor. During those 30 days we will continue to offer only urgent care.*

Initial:___

HAVING READ THE ABOVE, I AGREE TO ABIDE BY THE POLICIES SET BY CATON FAMILY PHYSICIAN CARE, PC AND THE STAFF. I REALIZE THAT ALL CHARGES INCURRED BY ME AND MY DEPENDENTS ARE MY FINANCIAL RESPONSIBILITY AND ALL COURT FEES, ATTORNEY'S FEES, OR OTHER FEES NECESSARY TO COLLECT ANY PAST DUE BALANCES ARE MY RESPONSIBILITY. FAILURE TO FOLLOW THESE POLICIES COULD RESULT IN MY IMMEDIATE DISMISSAL AS A PATIENT. I HAVE SIGNED THESE POLICIES OF MY OWN FREE WILL AND IN RIGHT MIND.

*Patient Signature*_____ _____ *Date*_____

Health History Intake Form

Today's Date:_____

Patient Name:_____

Date of Birth:_____ **Age:**_____

Previous Primary Care Physician (if any):_____

Phone:_____ **Address:**_____

Other Physicians involved in your care:_____

_____

Reason for visit today:

_____

_____

_____

Allergies (Medication/Food, indicate reaction): ☐ None

_____

_____

_____

Medication List: (Please list name/dose/frequency if known)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: (please indicate deceased or alive, medical issues and age)

Father:_____

Mother:_____

Siblings:_____

_____

Grandparents:_____

Habits:

Alcohol: ☐ None ☐ Yes: How many drinks/day _____ frequency/week _____ What kind_____
Tobacco: ☐ None ☐ Yes: Chew or smoke?_____ How many/day _____ since_____
Caffeine: ☐ None ☐ Yes: What kind_____ How many/day _____
Other Recreational Drugs: ☐ None ☐ Yes: What kind_____ How many/day _____
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much?_____

Social History:

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation _____ Former Occupation _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner
Sexual preference: ☐ Men ☐ Women ☐ Both
Children (age):_____
Hobbies:_____
Sports:_____
Pets:_____
Other:_____

Past Surgical History (indicate date if known)

- ☐ None
- ☐ Cataracts_____
- ☐ LASIK_____
- ☐ Tonsillectomy_____
- ☐ Thyroidectomy_____
- ☐ Adenoidectomy_____
- ☐ Coronary Bypass_____
- ☐ Cardiac Stents_____
- ☐ Pacemaker_____
- ☐ Heart Valve_____
- ☐ Gall Bladder_____
- ☐ Appendectomy_____
- ☐ Bowel/Stomach Resection_____
- ☐ Hemorrhoidectomy_____
- ☐ Bariatric surgery_____
- ☐ Hysterectomy_____
- ☐ Endoscopy_____
- ☐ Colonoscopy_____
- ☐ Hernia_____
- ☐ Spinal Surgery_____
- ☐ Tubal Ligation_____
- ☐ Bladder surgery_____
- ☐ Prostate surgery/resection_____
- ☐ C-Section_____
- ☐ Orthopedic/joints_____
- ☐ Other_____

_____
_____
_____
_____

Past Medical History:

Head Aches	☐ Yes	☐ No	Date: _____
Stroke	☐ Yes	☐ No	_____
Seizures	☐ Yes	☐ No	_____
Pneumonia	☐ Yes	☐ No	_____
Diabetes (Type 1 or Type 2)	☐ Yes	☐ No	_____
Thyroid Disease (Low or High)	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Hearing Loss	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Blood Clots	☐ Yes	☐ No	_____
☐ Pulm Emboli (lung clots)	☐ Yes	☐ No	_____
☐ DVT (leg clots)	☐ Yes	☐ No	_____
Heart Burn, Reflux	☐ Yes	☐ No	_____
Stomach Ulcers	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
☐ Coronary Disease	☐ Yes	☐ No	_____
☐ MI/heart attacks	☐ Yes	☐ No	_____
☐ Congestive Heart Failure	☐ Yes	☐ No	_____
☐ Atrial Fibrillation	☐ Yes	☐ No	_____
☐ Angina	☐ Yes	☐ No	_____
☐ Valve Disorder	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
Gastrointestinal Bleeding	☐ Yes	☐ No	_____
Hepatitis (A, B, C)	☐ Yes	☐ No	_____
HIV / AIDS	☐ Yes	☐ No	_____
Chronic Wounds	☐ Yes	☐ No	_____
Cancer (type)	☐ Yes	☐ No	_____
Urinary Tract Infections	☐ Yes	☐ No	_____
Incontinence	☐ Yes	☐ No	_____
Kidney Stones	☐ Yes	☐ No	_____
COPD (Emphysema, Bronchitis)	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Bipolar Disorder	☐ Yes	☐ No	_____
Anxiety	☐ Yes	☐ No	_____
Fibromyalgia	☐ Yes	☐ No	_____
Chronic Fatigue Syndrome	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Gout	☐ Yes	☐ No	_____
Osteoporosis	☐ Yes	☐ No	_____
Prostate Disease	☐ Yes	☐ No	_____
Breast Disease	☐ Yes	☐ No	_____
Erectile Dysfunction	☐ Yes	☐ No	_____

Other _____