Patient Registration / History

Charles Barker Jr. D.O. Family Practice

Patient____Todays Date_________

Last Name First Name Middle Initial

Street Address____

City ______________________________________ State ____________ Zip _______________

Sex: ☐ Male ☐ Female Date of Birth ___________ ☐ Single ☐ Married ☐Divorced ☐Widowed

Home Phone ________________ Work Phone ________________ Cell Phone _________________

Email address:______________________________________ Best way to contact you?____________

Social Security # _________________________ Driver's License # ___________________________

Race:____________ Language:____________ Ethnicity: ☐ Latino ☐ Non-Latino ☐ Other

Are you employed? ☐Yes or ☐No ☐Full time or ☐ Part Time

Employer Name ______________________________ Occupation ____________________________

Are you a student? ☐Yes or ☐No ☐Full time or ☐ Part Time

Parent/Guardian Information (If Minor):

Name ____

Last Name First Name Middle Initial

Employer Name ______________________________ Occupation ____________________________

Address ____ Phone _____________________

City ______________________________________ State ____________ Zip _______________

Social Security # ____________________________________ Date of Birth ______________________

Insurance Information:

Insurance Company Name ____

Policy # _____________________ Group # _____________________ Effective Date _____________

Primary Insured's Name ____

Primary Insured's Social Security # ____

Primary Insured's Date of Birth __________________________ Phone _________________________

If you have Medicare are you ☐ Retired or ☐Disabled

Emergency Contact Information:

Emergency Contact ____________________________________ Phone _________________________

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Family history:

Mother: Alive or Deceased Any health issues:____

Father: Alive or Deceased Any health issues:____

Brothers: # Alive______ # Deceased_______Health issues:______________________________________

Sisters: # Alive_________ # Deceased_______Health Issues:_____________________________________

The reason why you are requesting an appointment: ____

____

Assignments of Benefits and Authorization to Release Information

I hereby authorize this office to furnish my designated insurance carrier(s), Social Security Administration, Healthcare Financing Administration or intermediaries with any necessary information regarding my illness or injury. I authorize benefits under all claims to be made payable directly to this office. I understand that I am financially responsible to the physician for any charges that are not covered by the insurer. In addition, I authorize the release of any necessary medical records to physicians to whom I am referred to by this office.

Consent to Treat

I ____________________________ voluntarily give my permission to the health care Providers of Charles R. Barker Jr. D.O. and such assistants as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from clinic providers, or until I withdraw my consent.

Patient Signature ____ Date____________________

(If Minor Legal Guardian's signature)

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Check Any Conditions That <u>YOU HAVE:</u>

☐ diabetes ☐ hypertension / high blood pressure ☐ stroke ☐ kidney disease ☐ bowel disease

☐ migraine ☐ thyroid ☐ arthritis ☐ heart disease ☐ pacemaker ☐ asthma ☐ glaucoma

☐ COPD / emphysema ☐ anxiety ☐ depression ☐ bipolar ☐ schizophrenia ☐ osteoporosis

☐ cancer (list type) _____________ ☐ high cholesterol

☐ other ____

List Surgeries ☐ None

____

____

Check Any Conditions That <u>YOUR FAMILY HAS</u> (Parents, Siblings, Children):

☐ diabetes ☐ high blood pressure ☐ stroke ☐ kidney disease ☐ migraine ☐ bipolar

☐ arthritis ☐ heart disease ☐ asthma / COPD ☐ anxiety ☐ depression ☐ bowel disease

☐ osteoporosis ☐ schizophrenia ☐ cancer (list type) ____________________ ☐ high cholesterol

☐ other ____

Do you ***smoke?*** ☐ Yes ☐ No If yes, how much? ____________________

Do you ***drink alcohol?*** ☐ Yes ☐ No If yes, how much? ____________________

Do you use ***illegal drugs?*** ☐ Yes ☐ No If yes, what type? ____________________

LIST MEDICATIONS (AND STRENGTH AND HOW TAKEN): ☐ **none**

____

____

____

LIST ALLERGIES: ____ ☐ **none**

What Pharmacy do you use______________________________ City______________________________

THIS AREA FOR STAFF ONLY!

Patient History Reviewed For Completeness.

Provider Signature

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Charles Barker Jr. D.O. Family Practice

Dear Patient:

Welcome to Charles Barker Jr., Family Practice. We would like to take this opportunity to welcome you to our practice. This letter contains answers to some of the most commonly asked questions by patients entering our practice. We hope you will find this information useful.

Our facility is a Rural Health Clinic. Our office hours are Monday through Thursday from 7:00AM – 7:00PM and Friday 7:00AM – 5:00PM. Our office phone number is 616-794-1810.

We do understand that in today's busy world occasionally situations come up that are beyond your control. In those instances, we do request you extend us the courtesy of a 24-hour notice. This courtesy allows us to continue to operate efficiently and use the time that was reserved for you to help other patients in need. It is our policy that if you miss or do not call within 24 hours to cancel your appointment, three times within six months span you will be discharged from the practice, as well as any family member's living at the same address. We will not reschedule New Patient No Shows, you would then need to find a new doctor.

For the benefit of our patients we are contracted with several insurance carriers as a provider. You will want to check your benefits booklet or with the benefits department of your employer to verify if our physicians are listed as providers within your network. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any co-pays or deductibles from you at the time of service. We do ask that you be prepared to pay your co-pay at the time of check in. Your account may be assessed a $25 charge if payment is not received or you may be asked to reschedule. Failure on our part to collect these monies can result in cancellation of our provider contract. Patients who do not have insurance coverage will be expected to pay at the time of service.

As a Rural Health Clinic, we offer a sliding fee scale for essential services offered to individuals depending upon family size and proof of income. Please inquire within our office for more details.

We ask you allow for 24 hours to process any refills. Please leave any refill's you need on the refill request line. Be sure to speak clearly, leaving your full name, spelling your last name, date of birth, medication name, dose, how often you take the medication and what pharmacy you want it called into.

We are very excited to announce the launch of our Patient Portal. This is a secure and safe website where you can access your medical records, anytime, anywhere. You can and access refills, schedule appointments, view radiology and lab results, email your provider and more. When you provide any of our knowledgeable staff with your email, we will send you an invitation. You will be asked for a 4 digit security, this is your year of birth.

Regards,

Charles R. Barker Jr., D.O. and Staff