DR. J. COOPER MCKEE M.D.

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. J. Cooper McKee M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Dr. J. Cooper McKee

Health Questionnaire

Reason for Visit:

_____

_____

_____

Hospital Admissions: (indicate the year of hospitalization and the reason, DO NOT include normal pregnancies)

Year:	Illness or Operation	Year:	Illness or Operation
_____/	_____	_____/	_____
_____/	_____	_____/	_____

Drug Allergies: **Please Circle all that apply** Please list others:

Penicillin	Tetanus	_____
Anesthetics	Antitoxin and Serums	_____
Aspirin	Iodine	_____
Pain Medications		_____

Habits:

Cigarettes: How many packs a day? _____ How Long?_____ Quit Date?_____

Alcohol: How many drinks per week? _____

Coffee: How many cups per day? _____

Dr. J. Cooper McKee M.D.

WHO TO CONTACT:

I hereby give permission to Dr. J. Cooper McKee, M.D. and staff to disclose and discus any information related to my medical condition to/with the following family member(s), other relative(s), and/or close personal friend(s).

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

□ I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information reguarding my medical condition(s)

HOW TO CONTACT:

I wish to be contacted in the following manner:

Home #: _____ **Cell #:** _____

□ It is okay to leave a detailed message on my home or cell phone number.

□It is okay to mail to my home address _____

Street City State Zip

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

_____

Signature of Patient and /or Legal Representative

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Name: _____

Birthdate: _____/_____/_____ **SSN#:** _____

I understand that as part of my healthcare, this organization originates and maintains health records for future care or treatment.

I understand that this information serves as:

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source of information for applying my diagnosis and surgical information to my bill.**
- **A means by which a third-party payer can verify that services billed were actually provided.**
- **A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.**

I understand that I have the right to:

- **Request restrictions to how my health information may be used or disclosed to carry out treatment, payment of healthcare operations and that the organization is not required to agree to the restrictions requested.**
- **Revoke this consent in writing, except to the extent that the organization has already taken action in restrictions to the use of disclosure of my health information.**

I hereby authorize employees and agents, including physicians, physician assistants, and nurse practitioners of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians including consultants, associates, and assistants of the physicians office.

_____

Signature of Patient, Parent or Legal Guardian **Date**

If the Patient is a Minor:

I consent for _____ **to authorize evaluation and treatment for my child named herein when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures for the child named herein.**

The Duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

_____

Signature of Patient, Parent or Legal Guardian **Date**