Omega Family Medicine

REGISTRATION

PATIENT INFORMATION

Name ____ Social Security # ____/____/______
(Last) (First) (Middle Initial)

Address ________________________________ City ________________ State _____ Zip________

Date of Birth ____/____/_____ Home Phone ( ) ____ - ______ Cell Phone ( ) ____ - ______

E-mail ________________________________ Occupation ________________________

Sex ☐ M ☐ F Age ________ Race ________________

☐ Married ☐ Partnered for _____ years Pharmacy ________________________

☐ Separated ☐ Minor Employer/School Address ________________________

☐ Widowed ☐ Single Employer/School Phone ( ) ____-______

☐ Divorced

* In case of emergency, who should be notified? ________________________ Phone ( ) ____ - ______

Relationship to Patient ________________________

** Whom may we thank for referring you? ________________________

CANCELLATION NO/SHOW POLICY

We kindly request that patients give 24 hours' notice if unable to keep a scheduled appointment. With proper notice given we will gladly reschedule the patient to another day and time at no charge. Patients who are not present for a scheduled appointment and fail to give notice will be billed $25.00. This fee will be billed directly to the patient as we are not able to bill the insurance carrier for these fees.

Patient Signature ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to OMEGA FAMILY MEDICINE all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions. OMEGA FAMILY MEDICINE may use my health care information to my designated insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X____ Date ____/____/_____
(Signature of Patient, Parent/Guardian, or Personal Representative

____ ________________________
(Please PRINT name of Patient, Parent/Guardian, or Personal Representative) Relationship to patient

HEALTH HISTORY

Patient Name: ______________________________ Date of Birth: ____/____/______

Allergies: ____

Medications: (please list)

NAME:	STRENGTH:	DOSE:

Vaccination Status: (please list date if possible; or year)

Hepatitis #1, #2, #3: ____________________ Influenza: ____________________

Pneumococcal: ____________________ Tetanus: ____________________

Health Maintenance: (please list date if possible; or year)

Bone Density Scan: ____________________ Carotid Ultrasound: ____________________

Colonoscopy: ____________________ EKG: ____________________

Echocardiogram: ____________________ Mammogram: ____________________

Pap smear/Pelvic Exam: ____________________ Pulmonary Function/Spirometry: ____________________

Stress Test: ____________________

Childhood Illness: (please indicate yes or no)

Measles: ________________ Mumps: ________________ Chicken Pox: ________________

Other Major Medical Problems/Conditions: ______________________________________

ADULT MEDICAL HISTORY:

Surgeries/Hospitalizations	Date	Surgeon	Hospital

Family History: (please list all known diseases or conditions)

Father Medical History: ____________________

Mother Medical History: ____________________

# of Children: __________

Children Medical History: ____________________

# of Siblings : __________

Siblings Medical History: ____________________

Paternal Grandmother Medical History: ____________________

Paternal Grandfather Medical History: ____________________

Maternal Grandmother Medical History: ____________________

Maternal Grandfather Medical History: ____________________

Social History:

Marital Status: __ Married __ Partnered for ___ years __ Separated __ Minor __ Widowed

__ Single __ Divorced

Who do you live with? ____________________

In your home, are there? (Please check all that apply)

__ Pets __ Smoke Alarm __ Carbon Monoxide Detector __ Smoke Free Home
__ Smoke Free Work __ Guns in the Home?

Please indicate your:

Highest education level: ____________________ Occupation: ____________________

Diet: ____________________ Sleep Habits: ____________________

Tobacco Use Frequency: __________ times per ________ Type of tobacco: ____________________

Alcohol Use Frequency: __ Daily __ Weekly __ Monthly Amount: __________ drinks per __________

Drug Use: ____________________ Caffeine Use: ____________________

Exercise: ____________________ Tattoos/Piercings: ____________________

Sexually Active: __ Yes __ No Contraceptive Use: __ Yes __ No

Patient No-Show/Late Arrival Policy (attachment a)

At Omega Family Medicine, we strive to meet and exceed the expectations of all our patients and we are dedicated to providing you with the best care and services possible. We also strive to meet your needs by providing appointment times that best fit your schedule.

Time is specifically reserved for you on our schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to the clinic during your assigned time. This results in other patients not getting the care they need, when they need it.

Because of the great need for our services and extensive waiting list, we have implemented the following no-show and late arrival policy.

Omega Family Medicine policy states that 3 or more no-shows in a year's time is considered excessive. Patients who have no-showed 3 appointments will only be booked in the designated time block offered by the office you have no-showed with.

Patients arriving more than 15 minutes late for their appointment will be moved to the next open appointment slot or worked in between other patients at the discretion of the provider as time allows. This appointment may be brief in nature due to the need to work them in between other patients. You will be given the option to reschedule an appointment for another day.

I have read and fully understand the Patient no-show/Late Arrival Policy.

____ ____________________

Patient Signature/Parent or Guardian for Minor Date

Karisa Young, N.P. – Zia Sheikh MD. - Deborah Hughes, FNPBC

Lauren Bell, PAC - William F. Mills, MD – Supervising/Collaborating physician

***HIPAA* Compliant Authorization Form**

Patient Name: ______________________________________

Date of Birth: ____/____/____ **Social Security #:** ____/____/____

I hereby authorize ____

(Name and address of person required to make disclosure-Previous Health Care Provider)

Release to: ***Omega Family Medicine***

401 North Eighth Street

Olean, NY 14760

PHONE (716)379-8113

FAX (716)379-8115

All medical records that are in your possession for the last three (3) years, or records that are specified below:

**LAST 2 YEARS OF MEDICAL DOCS, MEDICATION LIST, and IMMUNIZATION RECORDS. **

ADDITIONAL: ____

Purpose of this disclosure is being made at the request of the individual for the following:

_____ *Change of primary care physician*

_____ *Coordination of care*

_____ *Other (please specify)* ________________________________

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE BELOW.

______________________________ ____/____/____

(Signature of patient) (Date)

______________________________ ____/____/____

(Signature of witness) (Date)

Omega Family Medicine
Controlled Substance Contract

Patient Name: _______________

The purpose of this agreement is to prevent misunderstandings about certain medications you may be prescribed for pain management, anxiety and sleep as well as any other controlled substances. This is to help you and your provider to comply with the law regarding controlled medications such as narcotics and sedatives as well as all other controlled medications, In the event that your provider deems necessary to prescribe these medications.

- I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

- I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines and all other controlled medications as well. Also, I may be dismissed from the practice.

- A drug-dependence treatment program may be recommended for assistance with tapering/stopping my medications when appropriate.

- I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

- I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

- I will not use any illegal controlled substances, including street drugs, nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent. I am aware that alcohol may increase the sedating effects of my medications.

- I will not share my medication with anyone.

- I will not attempt to obtain any controlled medications, including narcotic pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

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- If I require urgent or emergent treatment with a controlled substance, I will notify my provider's office on the next available business day during office hours.

- I will safeguard my pain medication from loss or theft. Lost or stolen medications will not be replaced.

- I understand that my pain medications and other controlled medications will not be refilled early for any reason.

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Controlled Substance Contract

Patient Name: ________________

- No refills will be available during evenings or on weekends by my provider or the covering provider.

- I agree to use: ____Pharmacy for filling my prescriptions for all of my pain medications and other controlled medications. If this pharmacy is unable to fill my prescription in its entirety, I will contact my provider within the next business day.

- I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy and the Attorney General's office, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this Agreement to my pharmacy, specialty physicians and local emergency room when needed. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also authorize my provider to get any and all records related to my prior controlled substance use.

- I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications and other controlled substances and I agree to assume the cost of such testing. My provider may also require pill counts to be performed.

- I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

- I understand that use of these medications may cause sedation/drowsiness and that my driving and/or operating machinery could be affected by these medications.

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- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document will be given to me if I request it.

Patient signature: ______________________________ Date: ________________

Provider signature: ____________________________ Date: ________________

Witness signature: _____________________________ Date: ________________

401 North 8th Street • Olean, NY 14760 • Phone: 716.379.8113 • Fax: 716.379.8115