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Rec. Date________
JFM Staff ________

New Patient Registration Form

Patient Information

Name: ______________________ Sex: ______ DOB: ______________ SSN: ______________
Address: ______________________ City, State, Zip ______________________
Home phone: ______________ Cell: ______________ Work: ______________
Email:____
Employer Name: ______________________ Marital Status: (please circle) S M D W
Spouse Name: ______________________ Preferred Language: ______________
Pharmacy Name: ______________________ Pharmacy Address: ______________
Insurance: ______________________ Subscriber ID: ______________________
Secondary Insurance: ______________________ Subscriber ID ______________
Emergency Contact: ______________ Emergency Contact Phone: ______________
Emergency Contact Address: ______________________________________

Parent Information if patient is a minor

Mother: ______________________ DOB: ______________
Mother Address (if different) ______________________________________
Father: ______________________ DOB: ______________
Father Address (if different) ______________________________________

No-Show Policy:
If you miss an appointment or cancel your appointment within (24) hours of your appointment time you will be billed a $25.00 no-show fee. Additionally, two no-shows or cancelations with less than (24) hour notice will be grounds for dismissal from the practice.

initial ________

Controlled Medication Policy:
Jefferson Family Medicine will not prescribe controlled substances or narcotics for non-cancer chronic pain. If you have any questions please ask your provider at the time of your new patient visit.

initial ________

Co-pay-Deductible Policy:
If your insurance requires a co-payment,it is expected at check-in. If your insurance plan has a deductible and co-insurance you will be expected to make a down-payment of $75 before you will be seen. If the provider agrees to see you without your payment a $10 billing fee will be imposed.

initial ________

HIV Test Consent:
Your health care provider is required to present an offer of HIV testing to all persons aged 13-64 years old regardless of apparent risk. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important information about your health and give you what you need to make good decisions for staying healthy and give you what you need to make good decisions for staying healthy.

________ I accept the offer of HIV testing
initials

________ No, I do not want an HIV test today.
initials

Laboratory testing policy:
In addition to a number of other labs such as choleserol,blood sugar and blood count, your health care provider routinely performs a urine toxicology (drug) screen on all new patients as part of the comprehensive care we provide.

________ I accept the screen
initials

________ No, I decline the screen
initials

I attest that the above information is correct and I have read and understand the aforementioned policies.

Patient Signature ______________________