

**PATIENT REGISTRATION FORM**

**Richard D. Adelman, MD Family Health Care**

7320 Six Forks Rd. Ste. 260 Raleigh, NC 27615

p (919) 846-9292

f (919)848-3638

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street Apt #

City State Zip code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: M F Social Security Number: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Method of Contact (circle one): Phone call Text Message

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Hispanic Non- Hispanic

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Do you have a Living Will? Yes No Healthcare Power of Attorney? Yes No (if yes, please provide a copy)

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

**Guarantor Information**

Responsible Party: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_  
Street Apt # City State Zip Code

Social Security Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

**Insurance Information**

**Primary Insurance**

Name of Insurance: \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance**

Name of Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL HISTORY**

Date \_\_\_\_\_

Name \_\_\_\_\_

Birthdate (mm/dd/yyyy) \_\_\_\_\_

Address \_\_\_\_\_

**CURRENT MEDICAL PROBLEM(S)**

Date of Onset

1	
2	
3	
4	
5	
6	

**HOSPITALIZATIONS** (include all surgeries, birth of children etc.)

Date	Hospital	Location	Reason

**MEDICATIONS** (List Prescription, Non-Prescription, Herbal Supplements)

Name	Reason for Medication	Times per day

**ALLERGIES** (Medications, foods, pollens, etc) \_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY** (List family members. Check all applicable illnesses)

	DM	Arthritis	Asthma	Allergy	Heart	COPD	Stroke	HTN	Anemia	Cancer (type)	Mental/Emotional	Alcohol	Age of Death
Spouse													
Children													
Mother													
Father													
Siblings													
Grandparents													
Paternal Grandfather													
Paternal Grandmother													
Maternal Grandfather													
Maternal Grandmother													

DM = Diabetes    Heart = Heart Failure, heart attack    COPD = Emphysema    HTN= high blood pressure

Substance use \_\_\_\_\_    Living Will/Advance Directives/HCP/A    Yes    No

Exercise \_\_\_\_\_ x per Week    Smoke \_\_\_\_\_ Packs per Day    Alcoholic Drinks \_\_\_\_\_ per Day

**Patient Consent for Use and Disclosure  
of Protected Health Information**

Richard D. Adelman, MD

I hereby give my consent for Richard D. Adelman, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Richard D. Adelman, MD's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Richard D. Adelman, MD reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard D. Adelman, MD, at 7320 Six Forks Road, Suite 260, Raleigh, NC 27615.

With this consent, Richard D. Adelman, MD may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Richard D. Adelman, MD may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Richard D. Adelman, MD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Richard D. Adelman, MD restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent I give permission to the practice of Richard D. Adelman, MD to obtain my current medication history from other providers I am seeing.

By signing this form, I am consenting to Richard D. Adelman, MD's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Richard D. Adelman, MD may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient's Name

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Today's Date

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Print name of Parent or Legal Guardian

**Richard D Adelman, MD**  
Family Health Care  
7320 Six Forks Road Suite 260  
Raleigh, NC 27615  
919-846-9292

**Financial Policy 2021**

We are pleased you have chosen Richard D. Adelman, MD as your family’s medical provider. We are committed to building a successful provider-patient relationship with you and your family. We provide the best possible care and service to you. We regard your complete understanding of our financial policy as an essential element of your care and treatment.

- We ask that you bring insurance card with you to every visit.
- If we are contracted with your current insurance, we will submit an insurance claim on your behalf.
- Copays, deductibles, coinsurance, and past due balances will be collected at the time of service. We will not bill you for copays unless you have made previous arrangements with our providers or our billing department.
- If your health insurance determines a service to be “not covered”, you will be responsible for the balance. If you are covered by Medicare, you will be notified in advance and asked to sign as Advanced Beneficiary Notice.
- For all services provided to minor patients and/or patients with guardians, the balance becomes the guarantor’s responsibility.
- If we are out of network with your insurance and your insurance company pays you directly for our services, you are responsible for payment and agree to forward that payment to us immediately.
- By signing below, you are acknowledging that your payment must be made in a timely manner and if not done so, a collection fee of 30% will be added to your balance and will be forwarded to a collection agency with potential credit impact.

By signing below, you agree to accept full responsibility as a patient receiving medical services and are responsible for minor patients under your care. Your signature verifies that you have read the above financial policy, understand your responsibilities, and agree to these terms.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Date: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_