REGISTRATION FORM

Martin Fox, M.D. & Associates

Plastic and Reconstructive Surgery
Cosmetic Surgery
Hand Surgery

Martin Fox, M.D. • Geoffrey Durham-Smith, M.D. • Maurine Waterhouse, M.D. • John W. Derr, Jr., M.D.

Acct. Number: _____
Date Entered: _____
Initials: _____
For Office Use Only

PATIENT INFORMATION

DATE: _____

PATIENT'S NAME (LEGAL) (NICKNAME)	MARITAL STATUS S M W DIV SEP	DATE OF BIRTH / /	AGE	SOCIAL SECURITYNO.	SEX
STREET ADDRESS ❑ PERMANENT ❑ TEMPORARY	CITY, STATE, ZIP CODE			HOME PHONE NO.	
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)		HOW LONG EMPLOYED?	BUSINESS PHONE NO.	
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE			CELL PHONE NO.	
NAME OF PERSON WHO IS INSURANCE POLICY HOLDER	EMAIL		WOULD LIKE TO RECEIVE INFORMATION ABOUT NEW PRODUCTS & PROCEDURES? ❑ Yes ❑ No		
HOW WERE YOU REFERRED TO THIS PRACTICE?	FAMILY DOCTOR AND ADDRESS				

IN CASE OF EMERGENCY CONTACT (NOT LIVING AT PATIENT'S ADDRESS)

1. NAME	HOME PHONE NO.	2. NAME	HOME PHONE NO.

SPOUSE'S NAME	ADDRESS	DATE OF BIRTH / /	SOCIAL SECURITYNO.
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE		CELL PHONE NO.

REASON FOR VISIT

IF THE PATIENT IS A MINOR OR FULL-TIME STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE				HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	DATE OF BIRTH	SOCIAL SECURITYNO.	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE				CELL PHONE NO.
FATHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE				HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	DATE OF BIRTH	SOCIAL SECURITY	HOW LONG EMPLOYED?	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE				CELL PHONE NO.

In order to control our cost of billing, we request that co-payments for office visits be paid at the time of service is rendered.
AUTHORIZATION: I hereby authorize the physicians indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. This office files your primary insurance as a courtesy. I understand that I am financially responsible for all charges whether or not covered by insurance.
THANK YOU

_____
Responsible Party Signature

Patient's Acknowledgment

I hereby acknowledge that I have been provided with the practice's Notice of Privacy Practices and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness Name: _____

Witness Signature: TSA

Date: _____

* SEE CLIP BOARD *

THE FINANCIAL POLICY OF MARTIN FOX, M.D. & ASSOCIATES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to treatment.

All patients must complete our registration form before seeing the doctor.

REGARDING INSURANCE

We will accept assignment of insurance benefits. The balance is your responsibility whether or not your insurance company pays. We cannot bill your insurance company unless you give us copies of all insurance cards to which you want your charges billed. You are expected to follow up with your insurance carriers to see that your claim is processed in a timely manner and are likewise expected to provide your carrier(s) with any information to complete processing of the claim. Your insurance policy is a contract between you and your company. We are not a party to that contract. Please be aware that some, and perhaps all of services or supplies provided may be non-covered under the Medicare/Medicaid Program and/or other medical insurance.

REFERRALS

Patients have the responsibility of obtaining referrals when required by their insurance plan. If claims are denied due to absence of referrals, the patient will be responsible for the charges.

LATE CHARGE

I clearly understand that it is my responsibility to make sure the bill is paid within thirty (30) days of the billing date. Unpaid accounts will be charged a monthly late fee.

COLLECTIONS

Should collection steps become necessary, patients and/or their responsible party will be assessed any reasonable attorney fees and court costs associated with said action. Any judgement will bear interest at the annual rate in effect on the date a complaint is filed. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

SELF PAY

Patients without insurance coverage and in cases where insurance coverage cannot be verified are expected to pay at the time of treatment unless prior arrangements have been made.

WORKER COMPENSATION

All pertinent information regarding Worker Compensation must be supplied at your initial visit. We must be able to verify with your employer the validity of your claim. To qualify as a Worker Compensation claim your employer must be willing to provide us the name of the insurance carrier and a phone number for the insurance company. Otherwise the visit and/or treatment will be considered the patients responsibility. Regardless the patient is ultimately responsible for the bill should the insurance carrier deny the claim or fail to pay in a timely manner.

MINOR PATIENTS

The parents or legal guardians of the minor are responsible for payment.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

x_____ Date_____

Signature of Patient or Responsible Party

MEDICAL HISTORY

Date _____

Patient Name _____ Date of Birth: _____

Reason for appointment _____

Height _____ Weight _____ Any recent weight gain or loss? _____

Occupation _____

Medical Doctor _____ Referring Doctor _____

Have you ever had any allergic or adverse reactions to medications? Yes _____ No _____

If yes, list these medications _____

Have you ever had any allergic or adverse reactions to latex? Yes _____ No _____

Have you been instructed to take antibiotics prior to a surgical procedure? Yes _____ No _____

Have you ever had any of following? (Circle yes or no).

Yes	No	Heart attack	Yes	No	Psychiatric care
Yes	No	Irregular heartbeat	Yes	No	Chronic diarrhea
Yes	No	Angina	Yes	No	Blood disease
Yes	No	Congestive heart failure	Yes	No	Arthritis
Yes	No	High blood pressure	Yes	No	Sinus problems
Yes	No	Circulatory problems	Yes	No	Stroke
Yes	No	Shortness of breath	Yes	No	Ulcer
Yes	No	Asthma	Yes	No	Chemical dependency
Yes	No	COPD, emphysema	Yes	No	Bleeding problems
Yes	No	Diabetes	Yes	No	Blood clots
Yes	No	Epilepsy	Yes	No	Kidney failure
Yes	No	Headaches	Yes	No	AIDS or other immuno-
Yes	No	Back or neck pain			suppressive disorders
Yes	No	Hepatitis, jaundice or liver disease	Yes	No	Thyroid disease
Yes	No	Cancer of any kind	Yes	No	Mitral valve prolapse

If you answered "yes" to any of the above diseases, please list your treating physicians(s).

_____

Please list all surgical procedures or operations you have had.

_____

_____

_____

MEDICAL HISTORY (PAGE 2) Date _____

Please list all medications and dosages. Include aspirin, over-the-counter medications, herbs, vitamins, supplements and diet pills:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History:

Are your parents or siblings living or deceased? List any medical problems:

Mother _____ Father _____

Brothers _____ Sisters _____

Habits:

Do you use tobacco? _____ Yes _____ No. If yes, how much? _____

Do you drink alcohol? _____ Yes _____ No. If yes, amount and how often? _____

Do you use illicit "street" drugs? _____ Yes _____ No.

If you are being seen for skin cancer, please answer the following questions:

Have you previously had skin cancer? _____

Has anyone in your family had melanoma? _____

Have you or any of your relatives had a problem with anesthesia? _____

(Women only)

Last menstrual period _____ Numbers of pregnancies _____

Number of children and their ages _____

Is there anything else we should know about your medical history? _____

When was your last mammogram? _____ Where was it taken? _____

_____

Is there a family history of breast cancer? Explain _____

The above information is accurate and complete to the best of my knowledge.

_____ Date _____

Patient or responsible adult

Reviewed by M.D. _____ Date _____