PATIENT REGISTRATION FORM

Welcome to our office. In order to serve you properly, we will need the following information. **(PLEASE PRINT)** All information will be strictly confidential.

Patient's Name:	**Sex** M F	**Birthdate:** ____/____/____ **Age** _____	**Marital Status:** Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Street Address:	**Patient's SSN:**
City: **State:** **Zip:**	**Cell Phone:**
Name of Employer	**Business Phone:**
Address:	**How long at current Employer?**
Occupation:	

Name of Spouse:	**Spouse's Birth Date:**	**Spouse's Phone:**
Reason for Visit:		
Person to Contact in case of emergency:	**Relationship to Patient:**	**Phone:**
EMAIL ADDRESS:		
Referred By:		
Pharmacy Used:		

Authorization for Information Release:

I, the undersigned, authorize you to release my protected health information to provide, coordinate, or manage my health care and/or other related services. My protected health information may also be provided to another physician, agency or other health care provider (example: a specialist, pharmacist, laboratory, radiology or home health agency) to whom you have been referred. This information will be used for the purpose of evaluation. By signing below you understand that we have posted our Privacy Practices in our office and that you only need ask us if you would like a personal copy.

AGREEMENT TO PAY: I, the undersigned, accept the fees charged as a lawful debt and promise to pay said fees including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other State.

_____ _____

Patient Signature **Date**

THANK YOU SO MUCH FOR JOINING OUR NEW AND INNOVATIVE PRACTICE.
WE WOULD TRULY APPRECIATE YOUR REFERRALS.

MEDAC, P.C.
JOHNNIE W. STRICKLAND, JR. MD
PO Box 681912
Prattville, AL 36068

HIPAA – Medical Information Release for MEDAC, P.C.

Effective March 2017

Due to **federal privacy guidelines under HIPAA (required April 2001)**; we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to your designated family members, caregivers, and friends, as well as pharmacists, hospitals, emergency medical personnel, and referral specialists about you or your minor (under 14 years of age) children's PROTECTED HEALTH INFORMATION (PHI). Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, telephone, answering machine, fax, mail or email as needed for your care to only those you have identified below. Power of Attorneys would be listed separately. By your signature below you also acknowledge that you received the Notice of Privacy Practices from MEDAC, P.C.

In order for us to do this, please list names, dates of birth and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

****PLEASE PRINT****

I, _____ (patient name or child's name) DOB: _____ give my authorization to the individual(s) listed below to discuss my medical care with you and/or your staff on my behalf.

NAMES	DOB	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any health information you do not wish to be given out please list below.

_____

DISCLAIMER (Complete only if you want *no one* else to have access to information.)

____**I do not want you to discuss my medical care with anyone other than myself.**

The above information is private and confidential and will be placed in your medical record. This authorization will remain in effect for this office until rescinded in writing or replaced with a new signed release.

Signature _____ (Relationship if minor) _____ Date_____

Witness _____ Date _____

Text Messaging and Email Program Consent Form

Text messages and emails sent by MEDAC, PC are used to communicate with our patients efficiently. If telephone numbers or email addresses change, it is possible that a loss of information may occur due to outdated patient data stored in the MEDAC, PC system. If this occurs, patient data may be sent to an outdated phone number or email address no longer controlled by the patient. By entering my phone number and email address below, I agree to hold harmless MEDAC, PC, Johnnie Strickland Jr., MD and his employees in the event of a loss of information.

Cell Phone Number: _____ Email Address: _____

Revised 3-20-2017

PATIENT HISTORY FORM

Name:
DOB:
Occupation:
Phone (Home)_____ Mobile:_____
Email address:_____
Your Preferred Pharmacy and telephone:_____

ALLERGIES: (Are you allergic to any of the following?)

	Penicillins			Codeine or Morphine			Merthiolate/Mercurichrome
	Sulfa drugs			Erythromycin or others			Aspirin
	Adhesive tape			Nail polish or other cosmetics			Tetanus or AntiToxin

Other Drugs:
Any Foods:

HOSPITALIZATIONS AND SURGERIES

Date	REASON	WHERE	Physician
	Tonsillectomy(tonsils removed)		
	Appendectomy (appendix removed)		

MEDICATIONS/HERBS/SUPPLEMENTS

Name of Drug/Vit	Strength	Frequency of use	Prescribing Physician

Name:_____

PAST MEDICAL HISTORY

	Headache		Lactose Intolerance		Depression
	Heart Murmur		Gallbladder Disease		Gout
	Peripheral Vascular Disease		Prostate Disease		Cancer
	Allergies/Hay Fever		Bowel Irregularity		Skin Cancer
	Asthma		Incontinence		Bronchitis
	Pneumonia		Sexual/Menstrual Dysfunction		GI Disorder
	Venereal Disease		Osteoporosis		Frequent Infections
	Nervousness		Hepatitis		Diabetes (High Blood Sugar)
	Anemia		Arthritis		HIV or AIDS
	Hypertension		Blood Transfusions		

CHILDHOOD ILLNESSES

	Scarlet Fever
	Chronic rashes
	Rheumatic Fever
	Mumps
	Measles
	Rubella
	Polio
	Asthma
	ADD/ADHD
	Diphtheria
	Tetanus
	Cancer
	Skin Cancer
	Other: Please list

IMMUNIZATIONS STATUS

	Date of Last Tetanus Shot
	Pneumonia Vaccine:
	Influenza Vaccine
	TB Skin Test
	Are Childhood Immunizatons Up to Date?
	YES NO Unsure
	SPECIAL TESTS: ever had?/ When?
	EKG
	Chest Xray
	Heart Tests
	Lung Tests
	Colonoscopy
	Mammogram

FAMILY HISTORY: Check all that apply

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart Disease						
High Blood Press						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Seizures						
Bleeding Disord						
Kidney Dz						
Thyroid Dz						
Mental Illness						
Osteoporosis						

SOCIAL HISTORY:

Smoke: # of Packs daily:_____ How many years smoking?:_____ Interested in Stopping?:_____ Exercise: Type_____ How Often:_____	Coffee: Cups Daily:_____ Sodas: Cups per Week?:_____ Alcohol: Type_____ Oz/day/week_____ Have you Ever been treated for Alcohol or Drug Addiction?_____	Sleep: Difficulty falling asleep:_____ Difficulty staying asleep:_____ Snoring:_____ Early morning awakening:_____ Daytime Drowsiness:_____