ALICIA CHEN, MD

4900 Bayou Blvd, Suite 107
Pensacola Florida 32503
Bayou Corporate Center
Office 850-607-6269
Fax 850-607-6279

NewPatientRegistration Form

PatientInformation		
LastName:	FirstName:	Middle:
BirthDate:	SSN:	Nickname:
Address:		Apt#:
City:	State:	Zip:
HomePhone:	Height:	Weight:
CellPhone:	Maywesendyouremindersviatextmessage? ○ Yes ○ No	
EmailAddress:	Maywecommunicatewithyouviaemail? ○ Yes ○ No	
Gender: ○ Male ○ Female	MaritalStatus: ○ Single ○ Married ○ Divorced ○ Widowed ○ LifePartner	
Race: ○ Caucasian ○ AfricanAmerican ○ Hispanic ○ AmericanIndian ○ Asian ○ Other		
EmergencyContactName:	RelationshiptoPatient:	
Phone Number:	DOB:	
Howdidyouhearabout ALC? ○ Doctor:_____ ○ Hospital ○ InsuranceCo ○ Family/Friend ○ Radio ○ TV ○ PhoneBook ○ PrintAd ○ Billboard ○ Website ○ Other:_____		

Ifpatientisunder 18,please listthe Responsible Party'sInformationBelow (Also,completeifpatienthas aLegalGuardian.)		
LastName:	FirstName:	Middle:
BirthDate:	HomePhone:	Work/CellPhone:
Address(*if differentfromabove*):		Apt#:
City:	State:	Zip:

Pleasefill outthefront and backofeverypage.

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Health History

Medical Insurance:	Policy Number:	Group:
Pharmacy:	Pharmacy Address:	

CurrentMedications

Listall ofthedrugscurrentlyprescribedforyouby any doctor.Please includeanyvitaminsand/orherbalsupplements.

DR. CHEN DOES NOT PRESCRIBE NARCOTICS FOR PAIN MANAGEMENT.

MedicationName *Ex:Lisinopril*	**Strength** *Ex:20mg*	**TimesTakenPerDay** *Ex:1timedaily*

Allergies: ○**NONE** Areyouallergictolatex? ○Yes ○No

Medication Allergies	Reaction

Please enter the month and year you lastreceived the followingimmunizations:

Influenza_____ Pneumonia_____ Tetanus_____ Zostavax_____

HaveyoureceivedtheGardisilvaccine? ○Yes ○No Ifso,hasyoureceivedall3shots? ○Yes ○No

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FamilyHistory

Placeacheckto indicateanyfamily membersthathave or have hadanyofthe conditionsbelow:	Father	Mother	Sons	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Diabetes												
High BloodPressure												
Asthma/Hayfever/Eczema												
Heart Disease/Stroke												
Thyroid Disease												
Bleeding/ClottingProblems												
Inherited/GeneticDiseases												
Seizures												
KidneyDisease												
Cancer												
Alcoholism/DrugAbuse												
PsychiatricDisorders												
Pleaseentertherequestedinformationforeachfamilymemberbelow:												
AliveorDeceased (A/D)												
Ifdeceased, AgeatDeath												

Pleaseprovideanydetailshere: _____

_____

_____

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MedicalHistory		
Check any area belowthatyou have, orhave had, symptoms/problemsand brieflyexplain:		
○ Skin:	○ Chest/Heart:	○ Head/Neck:
○ Ears:	○ Nose:	○ Throat:
○ Back:	○ Circulation:	○ Lungs:
○ Intestinal:	○ Bladder:	○ Bowel:
Have you had any recent changes inany ofthe followingareas?		
○ Weight	○ EnergyLevel	○ AbilitytoSleep

Ifapplicable, enter the date of the last exam/test you've had in the following areas:			
BoneDensity:	Colonoscopy:	Cholesterol:	BloodGlucose:

List any surgeries you've had below, please include the type and date ofsurgery.		**Please listany other problems orconcerns you'd like to discuss with your doctor below.**

Men	
Dateoflast ProstateExam:	DateoflastPSALevel:

Women				
DateoflastPapSmear:			DateoflastMammogram:	
Doyoustillhavemenstrualperiods? ○ Yes ○ No			Dateoflastperiod:	
# Pregnancies:	# LiveBirths:	# Miscarriage:	# StillBorn:	#Abortion:
Haveyouhada D&C,hysterectomy,or Cesarean? ○ Yes ○ No				
Pleaselistanymedicalproblemsyouhadwithanyof yourpregnancies:				

Pleasefill outthefront and backofeverypage.

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SocialHistory

AlcoholUse

Doyoudrinkalcohol? ○ Yes ○ No

Ifyes,whatkindandhowmanydrinksperweek?

Tobacco Use

Doyoucurrentlyuse tobacco? ○ Yes ○ No Ifyes,please choosetypefromselection belowandamountusedper day.

○ Cigarettes:____X per day ○ Chew or Snuff:____X per day ○ Pipe:____Xper day ○ Cigars:____X per day

Wouldyouliketoquit? ○ Yes ○ No

Areyoua previous smoker? ○ Yes ○ No Ifyes,whatyeardidyouquit?_____Howmany years didyousmoke?_____

CaffeineIntake

Please markthetypeand writethenumberofcupsof caffeineyouingest**daily**.

○ None ○ Coffee:_____ ○ Tea:_____ ○ Cola:_____

Drugs

Doyou,orhaveyou evertakendrugs,legalorillegal,otherthanover-the-countermedicationsthatwerenotprescribedfor you?
○ Yes ○ No Ifyes,pleasedescribe:

Sexual Activity

Areyoucurrentlysexuallyactive? ○ Yes ○ No

Ifyes,areyoutryingforpregnancy? ○ Yes ○ No

Ifnot,pleaselistwhichmethod(s)ofbirthcontrolis beingused:

Wouldyouliketospeakto yourphysiciantodayaboutyourrisk ofillnesses,suchas HIV,AIDS,and/orotherSTDs? ○ Yes ○ No

Exercise Habits

Describethetypeandamountofexerciseyoudoregularlyandhowoften:

LivingSituation

Doyoucurrently livealone? ○ Yes ○ No Ifnot,withwhom?_____

Occupation

Whatis yourcurrent,primaryoccupation?

Doyouhavemorethanoneoccupation? ○Yes ○NoIfyes, pleaseexplain howmanyandtype:_____

Advanced Directives

Doyouhavea living will oradvancedirectives? ○ Yes ○ No

Wouldyouliketospeaktoyourdoctoraboutthepreparationofthese? ○ Yes ○ No

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PatientConsentForm

I,the undersigned,herebyconsenttothe followingtreatment:

- Administrationandperformance ofall treatments
- Administrationofanyneedanesthetics
- Performance ofsuchprocedures as maybe deemednecessaryoradvisableinthe treatment ofthis patient
- Use ofprescribed medication
- Performance ofdiagnostic procedures/testsandcultures
- Performance ofothermedicallyacceptedlaboratorytests！that maybe considered medically necessaryoradvisablebased onthe judgmentofthe attendingphysicianortheirassigned designees

Ifullyunderstandthatthis is giveninadvanceofanyspecific diagnosis ortreatment.

Iintendthis consenttobe continuinginnature evenafter a specificdiagnosishas beenmade andtreatmentrecommended.The consentwill remaininfull forceuntil revokedin writing.

I,the undersigned,acknowledge thatALC Consultingwilluse anddisclose my informationfor the purposes oftreatment,payment,andhealthcare operations as describedin the Notice of PrivacyPractices.

Aphotocopyofthis consentshall beconsidered asvalidas the original.

Medicare Patients:Iauthorize torelease medical informationaboutme tothe Social Security Administrationorits intermediaries for myMedicare claims.Iassignthe benefits payablefor services toALC Consulting.

_____ Iacknowledge thatupon request,Icanbegiventhe ALC ConsultingNotice of PrivacyPractices.Iunderstandthatiflhave questions orcomplaints thatIshouldcontactthe PrivacyOfficial.

Icertifythatlhave readandfullyunderstandthe above statementsandconsentfullyand voluntarilytoitscontents.

PatientName(Printed)	Patient(orRepresentative)Signature	Date

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Effective June 1, 2012

Payment Policy

Inanefforttoprovidegreaterclarityconcerningourpaymentpolicy, thefollowingformisbeingprovidedfor yourconsideration. Weaskthatyouacknowledgereceiptofthisformwithadatedsignatureandreturnittous.

1. **Insurance:**Weparticipatein mostinsuranceplansbutif youarenotinsuredby a planwedobusiness with,paymentinfull is expectedateach visit.Ifyouareinsuredby a plan we dobusiness withbutdon'thave an up-to-dateinsurancecard, paymentin fullforeachvisitisrequireduntilyourcoverageis verified.Sinceyourinsurancebenefitsarenegotiated betweenyouandyourinsurancecompany,weask thatyoucontactyourinsurancewithanyquestionsyouhaveregardingyourcoverage.
2. **Co-payments&Deductibles:**Allco-payments,deductibles,andbalancesareduein fullandpaymentis requiredat timeofservice.If youcannotprovidepayment,yourappointmentwill havetoberescheduled.Thisarrangementis part ofyourcontractwithyourinsurancecompany.Failureonourparttocollectco-paymentsanddeductiblesfrompatients canbeconsideredfraud.Please helpusin upholdingthelawbypayingyourco-paymentordeductibleateachvisit. (If youdo**not**haveinsurance,weask thatyouallowourstaff toholdyourcreditcard,signedcheck,or$60.00cash untilyou check-outandpayforyourvisitinfull.)
3. **Proofof Insurance:**Youarerequiredtopresentyourinsurancecardanddriver's licensebeforeevery visittoprovide proofofinsurance.If youfail toprovideuswiththecorrectinsuranceinformationattimeofservice,youwill beaskedto pay thefullpriceofthevisit. (Onceinsuranceinformationisreceived,filed,anda payment madeby yourinsurance company,yourpaymentwill be refunded.)Ifyoucannotprovidepaymentattime ofservice,yourappointmentwill have tobe rescheduled.
4. **ClaimsSubmission:**Wewill submitall ofyourclaimsandassistyouinanyway we reasonablycantohelpgetthempaid. Ifyourinsurancecompanyneedsyoutosupply additionalinformation,pleasedosoquickly.
5. **CoverageChanges:**If yourinsurancecompanychanges,pleasenotifyusbeforeyournextvisitsothatwecanmakethe appropriatechanges.Thiswill helpyoureceiveyourmaximuminsurancebenefitsandhelpyouseethedoctorontime.If yourinsurancecompanydoesnotpayyourclaimwithin45days,theremainingbalance will beyourresponsibility.
6. **Nonpayment:**If youraccountisover90dayspastdue,youwill receivea letterstatingthatyouhave20daystopayyour accountinfull. (If necessary,you maysetupa paymentplantobeautomaticallydebitedfromyour bank account monthly.Inthiscase,wewill divideyourbalanceinto,nomorethan,3 equalpayments.) Please beawarethatif a balanceremainsunpaid,youraccountwill besenttoa collectionagencyandyoumaybedischargedfromthispractice. Ifthisoccurs,youwill be notifiedby certifiedmailthatyouhave30daystofindalternativemedicalcare.Duringthat30- day periodyourphysicianwill onlybeable totreatyouif thereis anemergency.
7. **MissedAppointments:**Our policyis tocharge$35.00 foreachmissedappointmentandforthosenotcancelledwithin24 hourspriortoyourappointmenttime.Thesechargeswill beyourresponsibilityandbilledtoyoudirectly.You will notbe seenatyournextscheduledappointmentuntilthischargeispaid.
8. **Check-InPolicy:**Thispolicyisinplacetokeepbothyouandyourdoctorontime.Our check-inpolicyrequiresyoutobe here15minutespriortoyourscheduledappointmenttime.If youarelateforyourcheck-intime,youcouldbe chargeda $35.00latefeeandyourappointmentrescheduled.

ALC Consultingis committedto providingthebesttreatmenttoour clientsand,asalways,wethankyouforthe opportunitytoservebothyouand yourfamily.Pleaseletus knowifyouhaveanyquestionsorconcernsregardingourpaymentpolicy.

Ihavereadandunderstandthepaymentpolicyandagreeto abidebyitsguidelines.

PatientName(Printed) Patient(orRepresentative)Signature Date

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AuthorizationforReleaseofInformationtoAnotherPerson

Patient'sFirst&Last Name(Printed):_____DOB:_____

Please listthe familymembers,spouse, orother person(s),ifany, towhomwemay release your personal medical information.

If authorized,ALC CONSULTINGmayreleaseyourinformationtoanyauthorizedperson(s) inperson orviatelephone regardingyourgeneral medicalcondition and/oryourdiagnosis (includingtreatment, payment,andhealthcareoperations).

AuthorizedPerson'sName:_____RelationshiptoPatient:_____

AuthorizedPerson'sName:_____RelationshiptoPatient:_____

AuthorizedPerson'sName:_____RelationshiptoPatient:_____

○ I doNOTauthorizeALC CONSULTINGtoreleasemyinformationto anyone

Notice:Thisauthorization is forfulldisclosureofpertinentrecords. If thereisanyinformation thatyou donotwantdisclosedtothenamedparty, pleaseindicatebelowwhatportionsoftherecord youwouldlikeexcluded.

Exclusions: _____

IherebygrantALC CONSULTINGthe approvaltodiscussmymedicalhistoryasoutlinedabove. Anyexclusions havebeen noted. Thisauthorizationwill remain ineffectuntilrescindedbymyselfin writing.

Patient(orRepresentative)Signature: _____Date: _____

Theserecordsareconfidentialand notfor re-releasebyany facilityotherthanALC CONSULTING.

Pleasefill outthefront and backofeverypage.