Horizon Family Medicine, PA
Multiple Locations With One Purpose...Your Health
www.horizonfamilymed.com

Established Patient Registration Form

Patient Information – *Please Print*

Legal Name: _____ Suffix: _____

SSN: _____ Date of Birth: _____ Email: _____

Home Address: _____ City, State, Zip: _____

Mailing Address: _____ City, State, Zip: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact

Name: _____ Relationship to Patient: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Privacy Information – *HIPAA – Communicating with your Family, Friends, or Caregivers*

I authorize Horizon Family Medicine to contact me and/or leave telephone messages in the following ways:

□ Home Phone: _____ □ Work Phone: _____

□ Cell Phone: _____ □ Email: _____

I authorize Horizon Family Medicine to release my medical information to the following people:

☐ Spouse: _____ Phone Number: _____

☐ Relative: _____ Phone Number: _____

☐ Other: _____ Phone Number: _____

☐ I DO NOT wish to release my health information to anyone besides myself. _____
(Initial Here)

Read and Sign Below

I certify that the information provided is correct and complete to the best of my knowledge.

Signature of Patient (Legal Guardian): _____ Date: _____

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been revoked: _____ (date)
This revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: _____ (date)

☐ Copy provided to patient/personal representative

Notes:

_____

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Patient Name: _____ Date of Birth: _____

ATTENTION: There may be two (2) billing codes at the time of an Annual Preventive Exam.

Insurance billing guidelines require separate billing for such services and/or tests when performed during the Preventive Exam.

- Preventive Exam itself
- Medical Management of current conditions or the diagnosis of new conditions. (See "Things NOT included in a Preventative Medical Exam" below) _____
  Initials

★If you prefer, we can often do both at one visit, if time allows, or you may choose to do this at two separate visits. In such instances, the patient is responsible for any co-pays or deductibles associated with such tests or service, in addition to the normal charge for the Preventive Exam. _____
Initials

A Preventive Exam is a checkup to assess your overall health and includes the following:

- Preventive Exams are also referred to as "physicals," "wellness exams," or "annual exams."
- An age and gender appropriate history and examination
- Prevention and health maintenance issues related to age, sex, and family history
- A review of risk factors and strategies to reduce those risk factors
- Preventive tests, routine labs, age appropriate cancer screening, mood screening, appropriate screenings for diabetes, cholesterol, anemia, kidney and liver diseases.
- Administration of age appropriate immunizations/vaccines
- Guidance about diet, exercise, and other advice/strategies to improve health

Things NOT included in a Preventive Exam appointment:

- Management of your current health conditions (example: high blood pressure, diabetes, high cholesterol, depression, anxiety, insomnia, arthritis, etc.)
- Issuing new or refill of prescriptions
- The diagnosis of any new problem that requires testing, referrals, diagnostic test, medications, etc.
- If we see any questionable indicators, we will usually ask that you schedule a return visit to allow time for proper time and treatment of new problems or chronic conditions.

Your health is our priority and your time matters. We appreciate you helping us maintain our appointment schedule as closely as possible.

Patient Signature: _____ Date: _____

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Health History Questionnaire / Preventive Health Screening

Name: _____ Date of Birth: _____
Address: _____
Home Phone Number: _____ Cell Phone Number: _____
Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please describe what problem or concern brought you to our office today:
☐ Primarily to establish care ☐ Other - please briefly describe:_____

Special Communication Needs: Requires Updating Annually					
Language preference:					
If 'yes' to any of the questions below, how can we assist?					
Visual impairment	☐ Yes	☐ No	Cognitive impairment	☐ Yes	☐ No
Hearing impairment	☐ Yes	☐ No	Sensory impairment	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No	Other:		

Personal Health History		**Previous Surgical Procedures**	
Please check past or current problems or conditions		Please check if you have had any of the following...	
Condition	Condition	Procedure	Year
	☐ Seizures		
☐ Hypertension	☐ Headaches	☐ Heart surgery	
☐ High Cholesterol	☐ Stroke	☐ Carotid artery surgery	
☐ Diabetes	☐ Prostate problem	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Breast problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Urinary tract infections	☐ Hysterectomy	
☐ Congestive heart failure	☐ Osteoarthritis	☐ Gallbladder removed	
☐ Asthma	☐ Cancer *(Please list type below)*	☐ Appendix removed	
☐ Emphysema/chronic bronchitis	_____	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesphageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental illness	☐ Pacemaker	
☐ Colon cancer	☐ Other *(Please describe below)*	☐ Other *(Please describe below)*	
	_____	_____	

Specialty Providers: Requires Updating Annually	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year you last saw them.	
☐ No new specialist visits since previous year	
	☐ Nephrologist
☐ Eye doctor	☐ Psychiatrist
☐ Cardiologist	☐ Allergist
☐ Oncologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other: _____

MEDICATIONS: Please list any medications you take, including over-the-counter, herbs and supplements. Also, include any medications prescribed by specialists or providers other than your PCP. Include dose and frequency.

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below…

Are you unable to fill your prescription(s) because of the cost? ☐ Yes ☐ No

Are you unable to fill your prescription(s) because of lack of transportation? ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance? ☐ Yes ☐ No

Allergies

Please list any allergies to medications or foods

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative
☐ Mental Illness	
☐ Chemical Dependency	
☐ Opioid Dependency	

Opioid History and Current Usage: Requires Updating Annually

It is very important that you take the medication(s) your health care professional has given you.
Please check any of the below...

- Have you ever taken drugs called Opioids (ex: Morphine, Oxycontin, Dilaudid, Fentanyl)? ☐ Yes ☐ No
- Are you currently taking any Opioid for chronic pain? ☐ Yes ☐ No
- Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy) ☐ Yes ☐ No

Social History: Initial / Requires Updating Annually

Please circle appropriate answers below and provide explanations where appropriate

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your current living situation: (Circle number)
Not Very Stressful 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:
_____

Are there financial concerns that affect your ability:
1) to go to the doctor ☐ No ☐ Yes If yes, describe: _____
2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:_____

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?
☐ No ☐ Yes If yes, describe:_____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other *(please describe below)*
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	Females – Please complete
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow: ☐ Reg ☐ Irreg ☐ Pain/cramps
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow__ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfullness	1st day of last period _____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _____
☐ Vomiting	☐ Arm ☐ Hips ☐ Back		Miscarriages_____
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Health Literacy Questionnaire:	
It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health.	0 1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home.	0 1 2 3 4 5 6 7 8 9 10
I feel that I have strong understanding of medical language.	0 1 2 3 4 5 6 7 8 9 10

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Year	Tests	Location	Year
Tetanus vaccine / Tdap ☐ Yes ☐ No		Pap smear / pelvic ☐ Yes ☐ No		
Pneumonia vaccine ☐ Yes ☐ No		Mammogram ☐ Yes ☐ No		
Influenza vaccine ☐ Yes ☐ No		Bone dexascan ☐ Yes ☐ No		
Shingles vaccine ☐ Yes ☐ No		Colonoscopy ☐ Yes ☐ No		
Covid vaccine ☐ Yes ☐ No		Prostate test ☐ Yes ☐ No		
Additional Vaccines taken since previous year ☐ Yes ☐ No If yes, list vaccine name and date:				

Health Behaviors: Requires Updating Annually for 11 years and older

Tobacco Use: ☐ Never ☐ Quit/when _____ ☐ Current Smoker
If current smoker, how many packs per day/for how many years _____

Alcohol Intake: ☐ Yes ☐ No
If yes how many drinks/how often _____

Illicit Drug Use (marijuana, cocaine, steroids) ☐ Never ☐ Past ☐ Current
If past or current drug use describe: _____

Exposure to secondhand smoke	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No
Wear a Seatbelt	☐ Yes ☐ No
See a dentist at least once a year	☐ Yes ☐ No
Wear sunscreen	☐ Yes ☐ No

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older

Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A Lot
During daily activities (work, household tasks)				
During physical activities (walking, exercising)				
During recreational activities (movies, hobbies)				
During social activities (out with friends, family visits)				
During car trips				

Fall Risk Screening: Requires Updating Annually for 65 years and older

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: Requires Updating Annually for 65 years and older

Do you need assistance in the following situations:	Not at all	A little	Sometimes	A Lot
Bathing, dressing and grooming				
Daily activities (cooking, cleaning)				
Walking or driving				
Communicating needs and feelings				
Understanding directions				
Keeping appointments				
Taking medications				
Performing other medical treatments				
If yes to any of these questions, who helps with these activities? _____				

Mood Screening: Requires Updating Annually for 11 years and older

A person's mood can have a strong influence on their health status and overall well being. Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	**Feeling down, depressed or hopeless**
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the day	☐ More than half the day
☐ Nearly every day	☐ Nearly every day

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____