Lehigh Valley Family Practice

1401 Fairmont Street
Whitehall, PA 18052-6015
(610) 432-4122

Patient Registration Form
(Please Print)

Narien K. Grover, M.D.
Diplomate American Board of Family Practice
Fellow of American Academy of Family Physicians

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ SS #: _____

Gender: Male Female *Marital Status:* Single Married Widowed Divorced Separated
(Please Circle)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone#:_____ Cell Phone#: _____ Work Phone#: _____

E-mail Address: _____

Employment Status: Employed Self-employed Unemployed Disabled Student Retired
(Please Circle)

Employer: _____

Employer Address: _____

Guarantor: Last Name: _____ First Name: _____
(If under 18, Parent/Guardian)

Address: _____

Date of Birth: _____ SS#: _____

Relation to Patient: Self Mother Father Spouse Other: _____
(Please Circle)

1) Insurance: _____ ID#: _____ Group#: _____

Policy Holder's Last Name: _____ First Name: _____

Date of Birth: _____ *Relation to Patient*: Self Mother Father Spouse Other: _____

2) Insurance: _____ ID#: _____ Group#: _____

Policy Holder's Last Name: _____ First Name: _____

Date of Birth: _____ *Relation to Patient*: Self Mother Father Spouse Other: _____

Whom may we thank for referring you? _____

Patient's Signature: _____ Today's Date: _____
(If Under 18 Parent/Guardian)

Please read and sign the back of form

Payment Policy

1. Payment in full is required at the time the service is rendered.

2. Patient is responsible for paying the co-payments, deductibles, if any, upon rendering services. **Our office *WILL NOT* bill for co-payments,** because your insurance requires collection of co-payment at the time of the service. If co-payment is billed after the service, there will be an administrative/billing charge included which is payable upon receipt.

3. Method of payments accepted: Cash/Personal Check/Credit Cards/Debit Cards.

4. If you ***do not*** have insurance or if your insurance ***does not*** cover office visits or any services, please let the billing office know, so that prior arrangements can be made.

5. There will be a $25.00 fee for appointments that are missed without a 24 hour cancellation notice.

6. If bills are neglected beyond two month time from date of service, there will be a $25.00 service charge added.

7. If your account remains unpaid for a period of 35 days, your account will be placed with our Attorneys/Collection Agency. You will responsible for the interest of 1.5% per month (18% APR) accruing from the original service date and for reasonable attorney and collection fees.

8. There will be a $35.00 re-deposit fee for all checks returned for insufficient funds. If the check is returned a second time another fee of $35.00 will be added as per our bank fee system.

9. Our office is not responsible for the insurance information that you provide as your coverage at the time of service.

10. A fee of $35.00 must be prepaid for all administrative forms filled on your behalf, such as FMLA, Short Term disability, Physical forms, etc.

11. You are responsible to establish a follow up, after you see any Specialists. You must bring Specialists recommendations with you.

Insurance Authorization

I authorize my insurance carrier to make payments on my behalf to Lehigh Valley Family Practice for any services rendered to me or my dependent. I understand that I will be responsible for all ***NON COVERED*** charges denied by my insurance carrier, including **deductibles, co-insurances, co-payments**, ***vaccines, telephone/internet consultation,*** and other **non-covered and non-payable services**.

I authorize Lehigh Valley Family Practice to release any information required to complete compensation and/or insurance claim to my employer/insurance carrier, pertaining to complete records of all my visits.

Immunization Authorization

I authorize Lehigh Valley Family Practice to provide me immunizations. The benefits, risks, side effects, complications, of the immunizing agent(s) are explained by the Physician/Physician Assistant/nurse upon immunization. I may refuse any immunization if I wish.

Immunization Acceptance: YES_____ NO _____

Date: _____

Patient's Name: _____

Patient's Signature: _____
(if under 18yrs old Parent/Guardian)

Relationship to minor: **Mother Father Guardian**
(Circle one)

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PATIENT DATA BASE

DATE

PERSONAL DATA	NAME_____ BIRTHDATE_____ ALLERGIES_____
MEDICAL HISTORY	High Blood Pressure Y N Eye Disease Y N Kidney Disease Y N Poor Circulation Y N Heart Disease Y N Arthritis Y N G I Disease Y N Allergies Y N Lung Disease Y N Cancer Y N Seizures Y N Diabetes Y N
	Other Y N (describe) _____ Hospitalization Y N (describe) _____ Surgery Y N (describe) _____
FAMILY HISTORY	List medical history/problems and comment state of health for each: • Mother _____ • Father _____ • Brothers _____ • Sisters _____
SOCIAL HISTORY	Do you use: Tobacco Y N What form: _____ How often: _____Duration: _____ Alcohol Y N How often: _____Duration: _____ Other Substances/ Drugs How often: _____Duration: _____ What type of drug: _____
HABITS	☐ Exercise Routine: _____ ☐ Contact with blood/bodily fluids At work/otherwise_____ ☐ Coffee: Cups Daily: _____ ☐ Difficulty Sleeping ☐ Disturbance While Sleeping ☐ Do you Snore? ☐ Daytime Drowsiness
MEDICATIONS	List all the medication/dose you are currently taking: 1. _____ 4. _____ 2. _____ 5. _____ 3. _____ 6. _____
VACCINATIONS	Please Provide a copy of childhood immunization records for pediatric patients. List ***all*** immunizations your child has already received and the date they were given. 1. _____ 4. _____ 2. _____ 5. _____ 3. _____ 6. _____

NAME: _____ DATE OF BIRTH: _____

HEALTH MAINTENANCE

ALLERGIES

PROBLEM LIST

PROBLEM	DATE	HOSPITALIZATIONS	DATE
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	

MEDICATIONS

	BEGUN	DC'd		BEGUN	DC'd
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

DATE									
AGE									
BREAST EXAM									
PAP SMEAR/PELVIC									
RECTAL/PROSTATE									
MAMMOGRAM									
EKG									
CBC									
LIPID PANEL									
THYROID PANEL									
PSA									
STOOL FOR BLOOD									
SIGMOIDOSCOPY									
MMR									
INFLUENZA									
TETANUS									
PNEUMOVAX									

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I understand that my medical records may be sent to another medical facility to ensure continuity of care. Other than releasing this information to any medical providers necessary, it is the office policy of Lehigh Valley Family Practice and staff not to release medical and/or confidential information to anyone other than the patient. If you give us permission to leave a message, the message for routine care will be to call our office. In the case of an emergent situation, the message will be to call our office in regard to an urgent matter.

I give permission for Lehigh Valley Family Practice and/or their staff to leave a message to call the office without divulging medical information pertaining to my care by the following methods, and will assume responsibility to notify them whenever this information changes.

Method	Yes	No	N/A	Phone # with area code
Home Telephone/ Answering Machine				
Work Telephone/ Voice Mail				
Cell Phone/ Voice Mail				
Pager				

I give permission for Lehigh Valley Family Practice to fax me any test results to me at my request. Yes _____ No _____
I give permission for Lehigh Valley Family Practice to address me by name when I am in the office. Yes _____ No _____

In the event that we are unable to contact you please list any desired alternative contacts:

Name	Relationship (Spouse, Parent, Sister, Brother, Boyfriend, Girlfriend)	Phone # with area code

Printed Name _____

Signature _____

Parent/Guardian Signature _____

Date _____