Stephen Kitchen M.D.FACS
A devotion to exceptional medicine.

3226 Hampton Avenue | Suite B
Brunswick | Georgia, 31520
(912) 265.0492

Patient Registration Form

Date: ___ /___ /_____

PATIENT INFORMATION:

First Name: _____ Middle initial: _____ Last Name : _____

SSN: _____ DOB: ____/____/____ Age: _____ Sex: **Male** **Female**

Address: _____

City , State, ZIP : _____

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

Email Address: _____

Race: **Black/African American** **Asian** **White** **More than one** **Refuse to report** **Other:** _____

Preferred Language: ***English*** **Hispanic** Other: _____

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy: _____ Pharmacy location: _____

Emergency Contact: _____ Phone number: _____

Marital Status: ***Single*** ***Married*** ***Domestic Partner*** ***Divorced*** ***Separated*** ***Widowed***

Please Circle one below:

Non Smoker ***Former Smoker*** ***Current smoker - some days***

Current smoker - every day - ***How many cigarettes per day?*** _____

Do you drink Alcohol ? **NO** **YES** If Yes – how much do you consume per week? _____

Employer: _____ Occupation: _____

If no employer noted please mark circle one : ***Retired*** ***Disabled*** ***Unemployed***

MEDICAL INFORMATION:

Reason for today's visit: _____

_____

Please list ALL DRUG **ALLERGIES**: _____

_____

If you have **No Known Drug Allergies** please initial here: _____

Please complete the reverse side of this form

NAME:

Existing & Previous Medical Conditions: (please Circle Yes or No and note date of diagnosis if yes)

HIGH BLOOD PRESSURE:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
CORONARY ARTERY DISEASE:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
DIABETES:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
MYOCARDIAL INFARCTION: *(Heart Attack)*	NO	YES	If YES > Date of diagnosis or age of diagnosis :
STROKE:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
CANCER:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
IF YES type of cancer:			
VENOUS INSUFFICIENCY:	NO	YES	If YES > Date of diagnosis or age of diagnosis :
LIST ALL OTHERS:			**DATE OF DIAGNOSIS OR AGE OF DIAGNOSIS:**

Please list previous surgical procedures:

Surgery	**Date:**

Family History: **if yes please circle family members diagnosed**

HIGH BLOOD PRESSURE:	Father Mother Sister Brother
CORONARY ARTERY DISEASE:	Father Mother Sister Brother
DIABETES	Father Mother Sister Brother
MYOCARDIAL INFARCTION (HEART ATTACK)	Father Mother Sister Brother
STROKE	Father Mother Sister Brother
CANCER:	Father - type of cancer -
	Mother - type of cancer -
	Sister - type of cancer -
	Brother - type of cancer -
VENOUS INSUFFICIENCY	Father Mother Sister Brother

OTHER: (please note which family member)

NAME: _____ DATE:_____

Date of Birth : _____

CURRENT MEDICATION LIST:

NAME OF MEDICATION	DOSE/STRENGTH	HOW OFTEN

OVER THE COUNTER / VITAMIN / HERBAL SUPPLEMENTS

NAME OF MEDICATION	DOSE/STRENGTH	HOW OFTEN

Please complete the reverse side of this form

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MEDICATION AGREEMENT & REFILL POLICY

As part of your treatment, Dr. Kitchen may prescribe medication for you. Many of these medications can have serious side effects if they are not managed properly. Your health and safety are important to us, and we need your help to make sure your treatment follows our guidelines. If we have any questions regarding your healthcare, including medications, **we reserve the right to contact your other treating physicians and pharmacies**.

1. I agree to follow the dosing schedule prescribed to me by Dr. Kitchen.
2. I understand that medication refill prescriptions involving narcotic pain medicine requires a **scheduled** office visit when Dr. Kitchen is on duty in the office and will NOT be refilled in between visits. **Narcotic pain medication refills CAN NOT be called into a pharmacy, nor can they be increased over the telephone**.
3. I agree to keep all scheduled appointments. **I understand that no medications will be given for cancelled or no-show appointments**.
4. I understand that medication refills cannot be made after hours, on weekends or holidays.
5. I understand that Dr. Kitchen will have no obligation to replace lost or stolen prescriptions or medications.
6. I understand that abusive behavior or harassment toward any of Dr. Kitchen's staff will not be tolerated. Harassment includes, but is not limited to, more than two (2) phone calls to the office in one business day.
7. I understand that I cannot present to Dr. Kitchen's office unannounced seeking medication refills.

By signing the agreement, you affirm that you have the full right and power to be bound by this agreement and that you have read, understood, and accepted these terms. No medications will be prescribed without acceptance of this agreement.

Patient's Name: _____

Patient's Signature: _____

Date: _____

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FINANCIAL POLICY

The patient is responsible for payment of the portion their insurance company does not normally pay (ie: *deductible, co-payment, co-insurance and the percent of the bill not generally covered by insurance*) at the time services are rendered. As a service to our patients, we will be happy to file your primary and secondary insurance for you. Once the patient's insurance company has paid their portion, or after we have waited for their payment for 30 days, you will be billed for any remaining charges not yet paid in full. If this account is not paid in full within 90 days of date of service it could be turned over to a professional collection agency with a fee of 35 % added to the account for this service. Patient will be responsible for any collection fees or court costs associated with the collection of any unpaid balances.

Patient initials_____

I authorize all clinical providers who have provided care to me, along with any office staff, billing services, collections agencies, attorneys, or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

Patient initials_____

Each insurance company sets different standards for treatment and reimbursement. Although the majority of our charges fall within most insurance companies' usual reasonable rates, our charges are not based on any one insurance company's fee scale.

Any medical referral forms, confirming of insurance coverage, and/or notification of the patient's insurance company are the patient's responsibility. The patient is financially responsible for any charges not covered by their insurance due to failure to obtain the appropriate referral forms/pre-certification, or prior insurance company approval.

Patients who do not have insurance, do not have proof of current insurance, or do not want us to file their insurance must pay the full balance at the time of service, unless other payment arrangement are made in advance of seeing the doctor.

For the convenience of our patients, we accept payment made by VISA, MasterCard, Discover, checks and cash.

I have read and agree to the FINANCIAL POLICY above.

_____ _____

Signature (If patient is a minor – parents signature required) Date

Please complete the reverse side of this form

Primary Insurance Information:

Insurance Company name: _____

Policy # _____ Group # _____ Person Insured: _____

Insured person's DOB: ___/___/___ Relationship: Self Spouse Parent Other

Secondary Insurance Information:

Insurance Company name: _____

Policy # _____ Group # _____ Person Insured: _____

Insured person's DOB: ___/___/___ Relationship: Self Spouse Parent Other

Responsible Party (if other than patient)

First Name: _____ Last Name: _____ Middle Initial: _____

DOB: ___/___/___ SSN# _____ Relationship: Self Spouse Parent Other

Employer: _____ Employer Address: _____

INSURANCE AUTHORIZATION

I hereby authorize Stephen F. Kitchen MD, its physicians and staff to release any information to any insurance company processing my claim, including the diagnosis and records in the course of my examination or treatment. I hereby authorize payment directly to Stephen F. Kitchen MD, and/or its physicians of the medical and/or surgical benefits otherwise payable to me but not to exceed the charges made for such treatment. A photocopy of this document is as valid as the original.

_____ _____

Patient Signature Required Date

(If patient is a minor –a legal guardian signature required)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____Date:_____

Relationship (if not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

*Presented on (date and time):*_____

*By (name and title):*_____

CONSENT TO PHOTOGRAPH

By signing this form, I agree and consent Stephen F Kitchen MD FACS, his affiliates, medical staff, agents and employees to photograph, me/the patient during interviews, diagnostic, and/or treatment sessions and surgical or medical procedures, for use by Stephen F Kitchen MD FACS for internal purposes, including but not limited to performance improvement, education and insurance authorizations/medical claims.

I understand that I will be provided a specific separate consent form by the office of Stephen F Kitchen MC FACS in order for the photographs to be made of me/the patient for external publication purposes.

1. You have the right to request that any photography be stopped.
2. You have the right to withdraw your consent to be photographed, up until a reasonable time before the photography is used.
3. If you want to activate any of your rights listed in 1 or 2 above please contact a member of the clinical staff to assist you.

Signed:_____Date:_____