LIFEBOAT
MEDICAL ASSOCIATES

Dr. Sara O'Heron, MD, FCFP, AAFP

Child Registration Form

Patient Name:_____
DOB:_____
Sex: Female____ Male____ Race:_____
Employed:Yes___No___ If yes, employer:_____
Social Security#_____
Parent/Guardian Name: _____

Home Address:_____

Phone:_____ Alternate Phone:_____
Email:_____

Insurance

Name of Insurance:_____
Member ID#_____ Group_____
Name of Policy Holder:_____
Policy Holder Date of Birth:_____

Emergency Contact

Name:_____ Phone #_____
Relationship to Patient:_____

Preferred Pharmacy

Name of Pharmacy:_____
Address:_____
Phone#_____

Signature (Patient or Guardian):_____

Printed Name: _____

Date: _____

Health History

Patient Name:_____ DOB:_____

Social:
Whom do you live with?_____

Status:
___Married ___ Single ___Divorced ___ Widowed ___Other

Occupation:_____

Do you exercise? ____ Yes ____No
Wear Seatbelt? ____ Yes ____No
Smoke Detectors in house? ____ Yes ____No

Do you/have you ever drink alcohol? ____ Yes ____No
How much?_____
How often_____

Do you/have you ever smoked? ____ Yes ____No
How much?_____
How often?_____

Do you/have you ever used street drugs? ____Yes ____No
How much?_____
How often?_____

Health Problems in the Past or Present:

_____
_____
_____

Hospital Admissions:

_____
_____
_____

Medications:

_____
_____
_____

Drug Allergies:

_____

Immunizations
please circle (If you have a record please give to the nurse to photocopy)

Tetanus	TB	Measles	Polio	Mumps
Influenza	Pneumonia	Rubella	Hepatitis	Diphtheria

Childhood Illnesses:

Chicken Pox	Measles	Rheumatic Fever	Mumps
Scarlet Fever	Other, Please explain:_____		

Family History

Relative	Age Now	Age When Deceased	Illnesses
Mother			
Father			
Sibilings			
Maternal Granmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Granfather			

Female:
Date of last pap smear? _____
Ever have an abnormal Pap smear? ____Yes ____No
If yes, how was it treated? _____
Date of last Mammogram? _____
Any abnormal Mammograms? ____Yes____ No
What birth control are you using? _____
Number of Pregnancies? _____
Number of live births? _____
Number of abortions?_____
Number of miscarriages? _____ _
Have ever been abused? ____Yes ____No

Male:
Sexually Active: ____Yes ____No

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Consent Forms

I give Lifeboat Medical Associates permission to give me medical treatment and file insurance benefits to pay for the care I receive. I understand that I have the right to refuse any procedure or treatment, and I have the right to discuss all medical treatment with my provider.

Patient or Guardian Signature_____

Printed Name_____

Date_____

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

This acknowledgment of receipt of the HIPAA Notice of Privacy Practice ("Acknowledgement") is being provided as a courtesy to its patients and is not legal advice nor intended to be relied on as legal advice. Your medical practice should consult with its legal counsel about the HIPAA Privacy Rule, the HIPAA Notice ofPrivacy Practices arid acknowledgment requirements prior to using this acknowledgment. This acknowledgment is intended to comply only with the federal HIPAA Privacy Rule Requirements. Medical practices are required to comply with state laws and rules. Acknowledgement may also need to be revised to reflect the privacy policies and procedures of your Medical practice. Your Medical Practice should consult with its legal counsel to revise this acknowledgment. HIPAA requires a Medical Practice to make a good faith effort to obtain a signed Acknowledgement from the patient at the time that it provides the HIPAA Notice of Privacy Practices to the patient.

I acknowledge that I have received a copy of this Medical Practice's HIPAA Notice ofPrivacy Practices.

Print Patient's Name_____

Signature of Patient/Guardian:_____

Date_____

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Contact List/ Consent to Release Information

In order to maintain patient confidentiality, we are unable to give medical information to anyone other than the patient or legal guardian without consent. This includes lab work, tests, x.-rays, medical diagnosis or condition.

I consent for (Print Name):_____
Relationship:_____DOB_____
Phone:_____ to receive medical records on (Patient's Name:)_____

I consent for (Print Name):_____
Relationship:_____DOB_____
Phone:_____ to receive medical records on (Patient's Name:)_____

I consent for (Print Name):_____
Relationship:_____DOB_____
Phone:_____ to receive medical records on (Patient's Name:)_____

I consent for (Print Name):_____
Relationship:_____DOB_____
Phone:_____ to receive medical records on (Patient's Name:)_____

Patient's Name:_____

Signature of Patient/Guardian:_____

Date:_____

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Grace Period

Our office utilizes a 15 minute grace period from your scheduled appointment time. I understand that in the event that I am later than 15 minutes I will be made to reschedule my appointment and the no show/same day cancellation fee will be charged. I also understand that excessive tardiness and/or missed appointments (3 no shows) will lead to my dismissal as a patient from the practice.

Patients Name:_____

Patient/Guardian Signature:_____

Date:_____

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No Show/Same Day Cancellation Policy

Your health is important to us, therefore as a courtesy, we use telephone information you provided us to give an appointment reminder call. Our system also sends out text reminders 2-4 days prior to the appointment date. It is ultimately your responsibility to keep your appointment or make any changes necessary; Our policy is to charge for any no shows, as well as, same day cancellations. Cancellations are accepted only by phone at this time. Please call our office directly during our business hours Monday through Friday. Thank you for compliance & understanding.

The fees are:

- **$25 for Ultrasounds & Dexa Scans**
- **$45 for Regular Visits**
- **$75 for Annual Wellness Exams**
- **$100 for Consults and/ or Procedure**

***Please note your medical insurance does not cover these fees.**

As of _____ I have been informed of this policy and understand that I will be dismissed from the practice after 3 no shows.

Patient name_____

Patient/Guardian signature_____

Date_____

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Past Due Balance Interest/Collection Fees

Lifeboat Medical Associates will add a collection fee of 30% to all balances that are sent to collections. Once your account is 120 days past due, it will be sent to our collection agency and you will be responsible for any collection and/or attorney fees.

Print Patient's Name:_____

Signature of patient/Guardian:_____

Date:_____