BILLERICA MEDICAL HEALTH CENTER

Internal Medicine - Functional Medicine - Women's Health

Patient Registration

Last Name: First Name:

Date of Birth: Age: Sex: *Male* ☐ *Female* ☐

Social Security Number: Marital Status: *Single* ☐ *Married* ☐ *Widowed* ☐

Address:

City: State: Zip:

Home Phone: ( ) - Work Phone: ( ) - Extension #:

Cell Phone: ( ) - e-mail address:

Occupation: Employer (or school):

Employer's Address:

In case of an emergency please notify: Name:

Phone: ( ) - Relationship:

Pharmacy used: Address: Phone: ( ) -

How did you hear about us?

I authorize the release of any medical or other information necessary to process claims. I authorize insurance payments to be made directly to Billerica Medical & Health Center. I understand that I am personally responsible for all deductibles and charges denied by my Insurance. Any lab or incidental charges at this or future visits will be my responsibility. FAILURE TO PROVIDE A 24-HOUR NOTICE OF CANCELLATION OF YOUR APPOINTMENT WILL RESULT IN A $75. FEE.

Patient Signature: *Date:*

RELEASE OF MEDICAL INFORMATION:

I authorize the release of any medical results or other medical information to:

Print Name: _____ Tel # _____ Relationship: _____

Print Name: _____ Tel # _____ Relationship: _____

Patient Signature: *Date:*

I have received the Billerica Medical & Health Center Medical Records Privacy Policy (HIPAA.)

Patient Signature: *Date:*

221 BOSTON RD SUITE 4
NORTH BILLERICA, MA 01862
WWW.BILLERICAMEDICAL.COM
Ph.(978) 670-1300 Fax.(978) 528-2024

BILLERICA MEDICAL HEALTH CENTER

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PERMISSION TO RELEASE MEDICAL INFORMATION

I give permission for Billerica Medical & Health Center to release my medical information to the following people: (Example-spouse)

Name	Relationship To You	Phone Number
_____	_____	_____
_____	_____	_____

I give permission for Billerica Medical & Health Center to call me at home:
(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical & Health Center to leave messages on my home answering machine:
(Check one) Yes _____ No _____

I give permission for Billerica Medical & Health Center to call me at work:
(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical & Health Center to leave messages on my work answering machine:
(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical & Health Center to contact me by email:
(Check one) Yes _____ No _____ Email _____

I give permission for Billerica Medical & Health Center to send messages about my medical condition by email:
(Check one) Yes _____ No _____

_____ _____ _____

Print Name Date

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BILLERICA MEDICAL HEALTH CENTER
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AUTHORIZATION TO RELEASE HEALTH INFORMATION
TO
BILLERICA MEDICAL & HEALTH CENTER

Patient Name: _____ Date of Birth: _____
(Please print)

Address: _____
Street Apt. #

_____
City, State Zip

I authorize _____

_____

_____

To release the following information to: **Billerica Medical & Health Center**
221 Boston Road Suite 4
Billerica, MA 01862

_____ Complete medical record, or
Clinical summary _____ Test results _____
Consults from others _____
Other (specify) _____

I authorize release of documents that may contain information about:

Alcohol or drug abuse	_____	Blood alcohol test results	_____
Mental Health information	_____	Sexual assault	_____
Venereal disease	_____	Domestic violence	_____
HIV or Aids	_____	Genetic testing	_____
Illegitimate births, abnormal births, fetal deaths			_____

I understand that I may revoke this authorization at any time by providing this office with a written and signed statement to that effect.

_____
Patient or legal representative signature Date

_____ _____
Printed name of signer, if not patient. Relationship to patient or authority to act for patient

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North Billerica, MA 01862
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BILLERICA MEDICAL HEALTH CENTER
Internal Medicine - Functional Medicine - Women's Health

AUTHORIZATION TO RELEASE HEALTH INFORMATION
FROM
BILLERICA MEDICAL & HEALTH CENTER

Patient Name: _____ Date of Birth: _____
(Please print)

Address: _____
Street Apt. #

_____
City, State Zip

I authorize release of the following information:

_____ Complete medical record, or
Clinical summary _____ Test results _____
Consults from others _____
Other (specify) _____

I authorize release of documents that may contain information about:

Alcohol or drug abuse _____ Blood alcohol test results _____
Mental Health information _____ Sexual assault _____
Venereal disease _____ Domestic violence _____
HIV or Aids _____ Genetic testing _____
Illegitimate births, abnormal births, fetal deaths _____

Please release the medical information to:

_____

_____

_____

This authorization will remain in effect for 90 days after the signature date. I understand that I may revoke this authorization at any time by providing this office with a written and signed statement to that effect. I understand that the cost for copying my medical record is $30.00.

_____
Patient or legal representative signature Date

_____ _____
Printed name of signer, if not patient. Relationship to patient or authority to act for patient

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INSURANCE COVERAGE INFORMATION

Services provided to you today may or may not be covered by your insurance carrier.

It is the patient's responsibility to be aware of what their insurance carrier will and will not cover.

Some insurance carriers will not cover services for the following:

Physicals
School Physicals
Immunizations
Travel Immunizations
Counseling
Contraceptive Management

I understand that I am personally responsible for all deductibles and any charges denied by my insurance carrier. I will pay my patient balance within 30 days of receipt of my statement from Joshi Medical Services, P.C. unless arrangements are made with the billing office.

I authorize the release of any medical or other information necessary to process this claim.

I have read the above information agree to these policies.

_____ _____
Signature Date

_____
Print Patient Name

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APPOINTMENT CANCELLATIONS

When we set aside time for you, we turn away other patients that wish to see the doctor. This means that both you and the other patient(s) are delayed in receiving care. Likewise the doctor wastes their time when a patient doesn't come in for their appointment. A missed appointment is an inconvenience for everyone!

As a **courtesy** to our patients, reminder calls are made one to two business days prior to the scheduled appointment. However, it is your responsibility to remember and make appropriate arrangements to keep your appointment. If for any reason you cannot keep make your appointment please call the office at least the day before.

Missed appointments are a serious concern. Our policy is that any patient who fails to notify us of a cancellation will be charged a fee of $75.00. Further, patients that cancel with less than prior day's notice on more than three occasions will be dismissed from the practice.

I have read, understood and agreed to the policies described above.

Name: _____
(Please print)

Signature: _____ Date: _____

9/21/06

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MEDICAL HISTORY

Today's Date:_____ Age: _____ Birthdate:_____

Name:_____ Sex: M___ F___

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Occupation:_____ Emergency Contact:_____

E-Mail:_____ Phone #: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Separated: _____

MEDICAL HISTORY

Check (✓) when you had any of the following symptoms or diseases. Please check appropriate column indicating past ○ or present ☐

- ○ ☐ Childhood Disease
- ○ ☐ Ringing in Ear
- ○ ☐ Ear Infections - *frequent*
- ○ ☐ Dizzy Spells
- ○ ☐ Fainting Spells
- ○ ☐ Failing Vision ○ ☐ Eye Pain
- ○ ☐ Double or Blurred Vision
- ○ ☐ Nose Bleeds - *recurrent*
- ○ ☐ Sinus Trouble
- ○ ☐ Sore Throats - *frequent*
- ○ ☐ Hoarseness - *prolonged*
- ○ ☐ Hayfever / Allergies
- ○ ☐ Pneumonia / Pleurisy
- ○ ☐ Bronchitis / Chronic Cough
- ○ ☐ Asthma / Wheezing
- ○ ☐ Shortness of Breath
  - ○ ☐ on exertion ○ ☐ lying flat
- ○ ☐ Chest Pain
- ○ ☐ High Blood Pressure
- ○ ☐ Heart Murmur
- ○ ☐ Swollen Ankles
- ○ ☐ Irregular Pulse ○ ☐ Palpitations
- ○ ☐ Leg Pain - *when walking*
- ○ ☐ Varicose Veins / Phlebitis
- ○ ☐ Cold Numb Feet
- ○ ☐ Loss of Appetite - *recent*
- ○ ☐ Difficulty Swallowing
- ○ ☐ Heartburn ○ ☐ Peptic Ulcer
- ○ ☐ *Persistent* nausea / Vomiting
- ○ ☐ Abdominal pain - *chronic*
- ○ ☐ Gallbladder trouble
- ○ ☐ Jaundice / Hepatitis
- ○ ☐ Diarrhea ○ ☐ Constipation
- ○ ☐ Inflammatory Bowel Syndrome
- ○ ☐ Bloody or tarry stools
- ○ ☐ Hemorrhoids ○ ☐ Hernia
- ○ ☐ Urination - Overactive Bladder
  - ○ ☐ Overnight more than twice
  - ○ ☐ Increased Frequency
  - ○ ☐ Urgency to Urinate
  - ○ ☐ with leakage
  - ○ ☐ Decrease in force / flow
    - ○ ☐ painful
  - ○ ☐ Stress incontinence - urine leakage with exercise / movement
- ○ ☐ Blood in Urine
- ○ ☐ Kidney Stones
- ○ ☐ Urine Infections - *frequent*
- ○ ☐ Sexually transmitted diseases
- ○ ☐ Sexual Problems
  - ○ ☐ Multiple Sex Partners
- ○ ☐ Weight Loss
- ○ ☐ Weight Gain - *recent*
- ○ ☐ Anemia
- ○ ☐ Bruise Easily
- ○ ☐ Blood Transfusions
- ○ ☐ Cancer ○ ☐ Chronic Fatigue
- ○ ☐ Diabetes ○ ☐ Thyroid Disease
- ○ ☐ Seizures ○ ☐ Stroke
- ○ ☐ Tremor / Hand Shaking
- ○ ☐ Numbness / Tingling Sensations
- ○ ☐ Headaches - *frquent*
- ○ ☐ Arthritis / Rheumatism
- ○ ☐ Back Pain - *recurrent*
- ○ ☐ Bone fracture/joint injury
- ○ ☐ Osteoporosis
- ○ ☐ Foot Pain ○ ☐ Gout
- ○ ☐ Rashes ○ ☐ Hives
- ○ ☐ Psoriasis ○ ☐ Eczema
- ○ ☐ Any type of sleeping difficulty
- ○ ☐ Depression
- ○ ☐ Nervousness
- ○ ☐ Agitation ○ ☐ Memory Loss
- ○ ☐ Moodiness
- ○ ☐ Suicidal Thoughts
- ○ ☐ Phobias ○ ☐ Mental Illness
- ○ ☐ Feelings of worthlessness
- ○ ☐ Rheumatic Fever
- ○ ☐ Scarlet Fever
- ○ ☐ Chicken Pox
- ○ ☐ Polio
- ○ ☐ Mumps ○ ☐ Measles
- ○ ☐ German Measles
- ○ ☐ Tuberculosis ○ ☐ Herpes
- ○ ☐ AIDS / HIV
- ○ ☐ Alcohol_____ oz. per week
- ○ ☐ Coffee/Tea _____ cups per day
- ○ ☐ Smoking: _____ cig / day
  - _____ # years
  - _____ year quit
- ○ ☐ Exercise
- ○ ☐ Street Drugs: _____
- ○ ☐ Acupuncture / Tatoos
- Hair Loss: ○ ☐ Progressive ○ ☐ Recent
- **MALES:** ○ ☐ Prostate problems
- **FEMALES:** *Please Complete*
- Menstrual Flow:
  - ○ ☐ Regular ○ ☐ Irregular
  - ○ ☐ Pain / Cramps
- Days of Flow: _____
- Length of Cycle: _____
- Date - 1st Day of last period _____
- ○ ☐ Pain / Bleeding during or after sex
- Number of:
  - Pregnancies _____
  - Abortions _____
  - Miscarriages _____
  - Live Births _____
- Birth Control Method: _____
- B.C. pill (name): _____
- ○ ☐ Flushing / Menopause
- Date of Last Pap Test _____
  - ○ ☐ Normal ○ ☐ Abnormal
- Date of Last Mammogram _____
  - ○ ☐ Normal ○ ☐ Abnormal

CURRENT MEDICATIONS

Prescription	Non-Prescription (Over the Counter)	Herbal/Non-Conventional

IMMUNIZATIONS

Tetanus / Td	
Influenza (flu)	
Pneumonia	
Hepatitis A	
Hepatitis B	
MMR	
Chicken Pox	
Polio	

ALLERGIES

FAMILY HISTORY

Follow the lines across and mark the appropriate cause of Death (age).

	Lives in good health	Deceased	Hypertension	Heart Failure	Epilepsy	Diabetes	Cancer	Asthma	Hay Fever	Arthritis	Kidney Failure	Glaucoma	Stroke	Migraine	Mental Health	Alcohol Abuse	Bleeding Disorder	Anemia	Psoriasis	Other
Father																				
Mother																				
Brother/Sister																				
Brother/Sister																				
Brother/Sister																				
Brother/Sister																				
Paternal Grandfather																				
Paternal Grandmother																				
Maternal Grandfather																				
Maternal Grandmother																				
Other Relatives																				

NOTES