Family Practice Center
34445 King Street Row
Lewes, DE 19958
302-645-2833

We would like to take this opportunity to welcome to the Family Practice Center.

Please bring the enclosed paperwork to the office for your first examination. We also ask that you bring the following items:

* Insurance Card
* Photo ID *(if you do not have a photo ID you must bring two bills with your name and address listed on the bills).* We reserve the right to not accept patients into the practice who cannot or will not present with photo identification, valid phone numbers or addresses that we cannot confirm.
* List of your prescription and non prescription medications

Our office will be calling to confirm your appointment the day before you are scheduled to arrive. If you have not provided us with a phone number, or you change your phone number and do not notify us of the change, it is your responsibility to call our office the day before your appointment to confirm. ***For patients without phone numbers or who have changed phone numbers, your appointment will be cancelled if you do not call our office to confirm.***

Sincerely,

Family Practice Center

Appt. date _____at the FAMILY PRACTICE CENTER

34445 King Street Row, Lewes, DE 19958 • (302) 645-2833

Last name first name middle initial

Social security # birth date marital status

Home phone # work phone # cell phone #

Address city state zip

Employer address phone

Emergency contact's name, address, phone number, relationship to you

Insurance company ident/acct# group #

Insurance card holder's name birth date social security number

Secondary insurance ident/acct# group #

Email address (for access to our website) Website user name

Pharmacy's name that you use most frequently

Ethnicity (please circle)

African -American Caucasian Hispanic Asian

Indian (India & Pakistan) Middle Eastern American Indian/Eskimo

Pacific Islander Mixed Other Undefined

NEW PATIENT HISTORY for _____

MEDICAL HISTORY (ie: Diabetes, heart attack, Cancer, high cholesterol or blood pressure)
1)
2)
3)
4)
5)
6)

SURGICAL HISTORY (ie: Hysterectomy, appendix, gallbladder, joint/back, heart)
1)
2)
3)
4)
5)
6)

HEALTH MAINTENANCE (approximate dates of most recent:)

Colonoscopy	Polyps	Y	N	
(F) Pap smear	Abnormal		Y	N
(F) Mammogram	Abnormal		Y	N
Bone Density	Abnormal		Y	N
(M) Prostate cancer screening (PSA/digital exam)	Abnormal		Y	N

Immunizations:
Tetanus when? 19____or 200___
Pneumonia when? 19____or 200___
Flu last 200___
Hepatitis B Yes No
HIV/Hepatitis test Never periodic surveillance

MEDICATIONS (including vitamins/herbal or alternative therapies**)**
1)
2)
3)
4)
5)
6)
7)
8)

MEDICATION ALLERGIES / INTOLERANCES
1)
2)
3)
4)

Please turn paper over and go to page 2

FAMILY HISTORY (illnesses and/or cause of death/age at death)
MOTHER living deceased

FATHER living deceased

SIBLINGS
 # brothers **# sisters**

SOCIAL HISTORY
1) cigarettes? Y/N Currently or quit Packs per day? ____ Aged started? _____
2) Alcohol avg # drinks/week _____
3) Marijuana/Cocaine/Pills/Ecstasy or other designer drugs/IV drugs/inhalants
4) employment history

5) Highest level education High School Completed Y/N College 2 YR/4YR/masters
6) sexual orientation heterosexual/homosexual/bisexual
7) long-term relationship Y N married or committed
how many times married? _____
7) children Names/ages

DAIGNOSTIC TESTING (When, why, outcome)
1) Stress tests/echocardiograms/EKG
2) CT scans
3) MRI
4) Endoscopy/cystoscopy
5) Biopsies

SPECIALISTS (names/specialties/reasons for seeing specialist)
1)
2)
3)
4)

Is there anything else about you that the doctor should be aware of?

Authorization for Disclosure of Protected Health Information

I, _____, authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I UNDERSTAND THAT, RECORDS MAY BE MAILED, FAXED OR SENT ELECTRONICALLY

1. I authorize the following person(s) and/or organizations to disclose my protected health information (as specified below:
   Name(s): _____

   Organization: _____

   Address: _____

2. I authorize the following person(s) and/or organizations to receive my protected health information, as disclosed by the person(s) and/or organization(s) above.
   ____ Family Practice Center 34445 King St Row Lewes, DE 19958 (302)-645-2833 fax (302)-644-4300

   Jerome Groll MD Cynthia Lowe MD Amy Robinson MD Alice Hopple FNP Cathy Barber, FNP

   Name(s): _____

   Organization: _____

   Address: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):
   ___ Office visit notes ___ Discharge summary ___ Medical Imaging (X-rays) ___ Laboratory reports
   ___ Operative reports ___ Any and all reports ___ Drug & Alcohol Treatment Info & Records
   ___ Mental Health Treatment Info & Records ___ HIV Treatment Info & Records
   ___ Genetic Treatment Info & Records
   ___ Any and all reports except_____

4. Specific description of the purpose for each use or disclosure:
   ___ At the request of the individual ___ At the request of parent/guardian ___ Legal reasons
   ___ Ongoing treatment by the Family Doctor ___ Educational planning/ongoing treatment

5. I understand that I may revoke this authorization at any time by sending a letter to the person or organization listed in the paragraph one, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. If I do not sign this form or if I later revoke my authorization, the services provided to me by the person or organization listed in paragraph one will not be affected in any way.

6. This authorization is valid for ***60 days*** and expires on ____/____/_____ or in the event that _____, whichever comes first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the continents are consistent with my direction.

Patient's Name: _____ Date of Birth: ____/____/_____

Address: _____

Telephone: _____ Social Security #: _____-____-_____

Signature: _____ Date: ____/____/_____

Relationship or Authority of Personal Representative (if applicable): _____

The Family Practice Center
34445 King Street Row
Lewes, DE 19958

CONSENT FOR RELEASE OF INFORMATION OF PRIOR AND CURRENT PRESCRIPTIONS

DATE_____ PATIENT_____

I, _____, authorize the Family Practice Center

to obtain the current and prior record of my prescription medications from the pharmacy computer data bases.

_____ _____
Patient Signature Witness

_____
Relationship to patient

Family Practice Center
34445 King St Row
Lewes, DE 19958
302-645-2833 978-327-7891

PRIVACY PRACTICES ACKNOWLEDGEMENT

This Notice serves as written documentation of your rights to privacy and confidentiality for your medical records under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA requires physicians to protect the confidentiality of medical information. The privacy regulation allows physicians to discuss patient information with fellow providers. The regulations require physicians to make a reasonable effort to disclose and use only that information which is necessary for treatment, securing payment, and conducting standard organizational duties such as audits.

Privacy is an individual's right to control access and disclosure of protected, individually identifiable health information. The Family Practice Center is responsible for security of your confidential medical information. This will be achieved by employee and physician training which will be done upon hire and maintained on a yearly basis. Records requested by The Family Practice Center are confidential and will be used to ensure you receive quality care by our physicians. If you authorize release of our records you will be asked to sign a separate release form and only those records necessary for you to receive quality care and authorized by your physician will be released by The Family Practice Center.

The Family Practice Center has always been and remains committed to the policy that compliance with federal and state laws and adherence to our own ethical standards of the medical profession are of primary importance. As part of our commitment, our Practice affirms the following:

1. Our patients are the cornerstone of our Practice. The relationship between patients and our
staff must be built upon honesty, credibility, professionalism, and mutual respect.

2. It is our responsibility as members of The Family Practice Center to observe all laws and regulations. We must at all times be honest and forthright in our dealings.
3. Our personal and professional integrity is our most important attribute.
4. Each physician, employee, and contractor of the Practice must read our compliance standards and procedures and commits to understand the importance of compliance with the law. Yearly certification and review of our Corporate Code of Conduct will be signed by each physician, employee, and contractor.

Our appointment notification policies are as follows; our office will call your home phone number or work number (whichever is given when the appointment is scheduled) and confirm your appointment. If you have an answering machine a brief message will be left stating your provider's name, date, and time of appointment. If you would like to request us not to call to confirm an appointment or mail a recall card, please notify our receptionist when scheduling any appointments. Your signature below documents that I have received the Notice of Privacy Practices and my understanding of my right to privacy, obtaining and releasing medical information, and our commitment to providing quality care and security of my information.

_____
Patient's Signature

_____
Parent's (or guardian) Signature

_____
Date of Notice

THE FAMILY PRACTICE CENTER
34445 KING STREET ROW
LEWES, DE 19958
PHONE: 302-645-2833

JEROME E. GROLL, M.D.*AMY J. ROBINSON, M.D.*ALICE E. HOPPLE, FNP*CATHERINE BARBER, FNP

SIGNATURE ON FILE

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS

I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL

I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANIES

I AUTHORIZE PAYMENT DIRECT TO MY DOCTOR

I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGIANAL

I AUTHORIZE A RELEASE OF MY INFORMATION TO ALL OF MY REFERRING PHYSICIANS

I UNDERSTAND THAT THIS OFFICE MAY PROVIDE ME WITH THE NOTICE OF PRIVACY PRACTICES WHEN REQUESTED AND OBIDES BY THE SATED INSTRUCTIONS ON THAT DOCUMENT

NAME (PRINT) _____

NAME (SIGNATURE) _____

DATE _____/_____/_____