Holcombe Emergency Medicine, P.A.
(aka "Holcombe Family Medicine")
NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION _____ (please PRINT)

Patient's Legal Name:

(Last) _____ (First) _____ (MI)_____

Preferred full name (if different from above): _____

Date of Birth: MM _____/DD _____/YYYY_____

Social Security Number (Medicare only): _____

Email address: _____

Address: _____

City, State, Zip: _____

Cell Phone: _____ Work: _____

Home Phone (landline): _____

Gender Identity:

[ ] Male	[ ] Female
[ ] Transgender Female to Male	[ ] Transgender Male to Female
[ ] Choose not to disclose	[ ] Other _____

Race:

[ ] White	[ ] Black/African American
[ ] Hispanic	[ ] Asian
[ ] American Indian/Alaska Native	[ ] Native Hawaiian/Pacific Islander
[ ] other	[ ] choose not disclose

Preferred Language: [ ] English [ ] Spanish [ ] other _____

How would you prefer to be contacted for appointment reminders, results, etc?

_____

RESPONSIBLE PARTY INFORMATION (if not self)
(information used for billing):

Responsible party: [ ] self [ ] another patient [ ] Guarantor
[ ] Check here if address & phone number are the same as "another patient" above.

Responsible party name:

(Last) _____ (First) _____ (MI)_____

Responsible Party Date of Birth: MM _____/DD _____/YYYY_____

Responsible Party Sex: [ ] male [ ] female

Responsible Party Social Security Number: _____

Responsible Party Address: _____

City, State, Zip: _____

Cell Phone: _____ Work: _____

INSURANCE INFORMATION:
If you want to submit your doctor's office visit costs to your insurance company, for reimbursement from them, provide the full name of your insurance company:

_____.
If the reimbursement form is available at the office, it will be provided to you.

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name:

(Last) _____ (First) _____ (MI)_____

Phone Number_____ Relationship to Patient: _____

Address: _____

City, State, Zip: _____

Do you have a: [ ] Living Will [ ] chosen a healthcare surrogate
[ ] appointed a healthcare poweer of attorney

MEDICAL HISTORY:_____

Height: _____ Weight: _____ Preferred Pharmacy: _____
Pharmacy Phone: _____

Current or most recent primary care physician:

Name: _____ Phone: _____

Other physicians or specialists you currently see, that help mange your care:

Name: _____ Specialty/Reason: _____

Phone: _____

Name: _____ Specialty/Reason: _____

Phone: _____

Name: _____ Specialty/Reason: _____

Phone: _____

Medication allergies:

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication intolerances:
(not an allergic reaction, but has bad side effects for you):

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other true allergies (eg. Latex, bees):

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

Substance: _____ Reaction: _____

PAST MEDICAL HISTORY: _____

Current medical problems (managed, or not yet managed),
prior surgeries & hospitalizations (with *approximate* dates if possible):

_____

_____

_____

_____

_____

_____

_____

_____

GENERAL CONSENT FOR CARE, & TREATMENT CONSENT _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition & the recommended surgical, medical or diagnostic procedures to be used, so that you may make the decision whether or not to undergo any recommmended treatment or procedure, after knowing the risks & hazards involved. At this point in your care, no specific treatment plan has yet been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable & necessary medical examinations, testing & treatment. By signing below, you are indicating that: (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made & treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.
The consent will remain fully effective until it is revoked in writing.
You have the right at any time to discontinue care and medical services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your physician, we encourage you to ask questions. You, as a patient, voluntarily request a physician, and/or mid-level provider and other healthcare providers, or their designees as deemed necessary, to perform reasonable & necessary medical examination, testing & treatment for the condition which has brought you to seek care at this practice. You understand that if additional testing, invasive or interventional procedures are recommended, you will be asked to read & sign additional consent forms prior to the test(s) or procedure(s).

You have the right to disagree with any diagnosis or treatment plan offered, and you are encouraged to talk about any disagreement(s) in treatment with your physician. No-one is perfectly correct 100% of the time, and your opinion, as a patient seeking care, is valued and respected.
After reasonable discussion of the issue in disagreement, if you feel that the differences cannot be reconciled, or a reasonable compromise reached, you should feel comfortable in seeking care with a different physician, understanding that there will be no "hard feelings" or anger or resentment from us. The same applies if you feel that our personalities "do not match" and you would prefer care with a different physician.

DISCLAIMER: We. at this practice, promise that we will always recommend care that is for your benefit & for your best interests, even though it may not be what you want to hear or were expecting. We do not encourage or support treatments that primarily involve chronic prescribing of controlled substances, such as benzodiapines (eg. Xanax, Ativan), or opiates (eg. Lortabl, Percocet); those conditions should be managed by an appropriate physician, not a primary care physician.

I certify that I have read and fully understand the above statements, and I consent fully and voluntarily to its contents.

Signature of patient/personal representative: _____

Printed name of patient/personal representative: _____

Relationship to Patient: _____

Date: MM _____/DD _____/YYYY_____

(last updated May 2020)