JOHNSON MEMORIAL HEALTH

FAMILY MEDICINE

Sean D. Beeson, DO
Robert D. Kavelman, MD
Clinton M. Knapp, DO
Diane M. Kolody, MD
Gerald B. Mader, MD
Susan Stormzand-Murphy, MD
John P. Wiseman, MD
Patricia Godeke Wiseman, MD
Katie E. Christian, FNP-C
Jill Hippenmeyer, FNP-C
Jenny A. Lee, NP-C
Hannah Rhea, PA-C

Appointment Date:_____ **Appointment Arrival Time:**_____

Welcome to Johnson Memorial Health Family Medicine!

To ensure you receive the highest quality of care and service, there are specific requirements we ask you to observe. If you have any questions or concerns, please contact our office before your office visit. The most important information is outlined below. Please be aware we reserve the right to reschedule your appointment without these items.

Patient Information: Enclosed is a Patient Registration and Medical History Form. Please complete these forms prior to your arrival and present them to the front office when you arrive.

Insurance Cards: We require a copy of your current insurance card(s) at each visit in order to bill your insurance. If you are unable to provide insurance information at the time of your office visit, we will consider you uninsured and will bill you as a private pay patient.

Photo Identification: To protect the identity of each of our patients and to comply with federal laws, we are required to view a photo ID or valid driver's license at every visit. We reserve the right to reschedule your appointment if you do not present a photo ID.

Current Medication List: To help your provider understand your overall health status and to expedite entering your medical history, we require patients to bring a list of current medications including medication name, dosage, and frequency. Controlled substances being used as maintenance medication will not be called in after hours or on weekends. These medications may require a hand-written prescription.

Late Arrival: Patients are required to be on time for their scheduled appointments. New patients should arrive 20 minutes early with their new patient packet. Additional paperwork may be required before being seen. In the event of late arrival, it will be at the provider's discretion whether he/she will be able to see you. Please note you may be asked to reschedule your appointment in order to maintain the integrity of the provider's schedule.

Cancellations/No Shows: If you are unable to keep your appointment, you are required to give a 24 hour notice. If you do not show or cancel your appointment too late, a fee will be charged to your account. Future appointments will be suspended until the fee associated with the missed appointment has been settled. The related fee for a no-show or late cancellation is $75 for a new patient and $35 for a follow-up appointment. The applied fee cannot be billed to your insurance carrier and will be a direct expense to you.

Co-Pays and Uncollected Balances: Our Patient Service Representative will collect your insurance co-pay at the time of check-in. If you have a previous balance for services performed at Johnson Memorial Health, payment will be required. Unpaid balances may result in bad debt collections and possible dismissal from our practice. In the event an account is sent for collection proceedings, the guarantor of the account will be responsible for all collection's costs.

Medical Records: Upon written request and signature, a copy of your medical records will be released to you. This process can take up to 5 business days. The state of Indiana has imposed a predefined fee schedule for copying medical records that will be charged accordingly to the patient.

Prescriptions: Our providers prescribe enough medication to last you to your next appointment. We will not refill medication before your visit. To avoid complications of your medical treatment and to prevent a lapse in medication, it is imperative to keep your scheduled appointments.

We look forward to meeting you and establishing a relationship to meet your healthcare needs!

FRANKLIN	1155 West Jefferson Street, Ste. 101, Franklin, IN 46131	P 317.736.6133 F 317.736.6403
STONES CROSSING	3000 South State Road 135, Ste. 200, Greenwood, IN 46143	P 317.535.1876 F 317.535.5049
WHITELAND	8 North US 31 North, Whiteland, IN 46184	P 317.535.1577 F 317.535.6345

JOHNSON MEMORIAL HEALTH

FAMILY MEDICINE PATIENT REGISTRATION FORM

Patient Information

Patient Name	
Street Address	
City, State, Zip	
Date of Birth	
Sex	
Social Security #	
Email Address	
Home Number	
Mobile Number	
Work Number	

Guarantor Information

Guarantor Name	
Street Address	
City, State, Zip	
Date of Birth	
Sex	
Social Security #	
Email Address	
Home Number	
Mobile Number	
Work Number	

Emergency Contact Related Person

Name	Relationship	Home Phone	Mobile Phone

Primary Insurance

Payer Name	
Health Plan Name	
Contact Number	
Group Number	
Member Number	
Name on Card	
Start Date	

Primary Subscriber Information

Name	
Relationship	
Address	
City, State, Zip	
Date of Birth	
Home Number	
Mobile Number	
Employer	

Secondary Insurance

Payer Name	
Health Plan Name	
Contact Number	
Group Number	
Member Number	
Name on Card	
Start Date	

Secondary Subscriber Information

Name	
Relationship	
Address	
City, State, Zip	
Date of Birth	
Home Number	
Mobile Number	
Employer	

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to this provider for all covered medical services and supplies provided to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Authorization to Release Information

I authorize the release of any medical or any other information to the Center of Medicare and Medicaid (CMS), my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by this provider. A copy of this authorization will be sent to CMS, my insurance carrier(s), or other medical entity, if requested. This arhoziaton will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Legal Guardian _____ Date_____

Print Name of Patient or Legal Guardian _____

NEW PATIENT INFORMATION / Medical History
(Family Physicians of Johnson County)

Name: _____ **Gender**: _____ **DOB**: _____ **Date:** _____

Please list what you would like to discuss today at your appointment:
1) _____
2) _____

PHARMACY:

Local:_____ Mail Order:_____

ALLERGIES:

Allergies to medications with REACTION/S: _____

_____

Allergies to food / environment / other with REACTION/S: _____

MEDICATION LIST:

List ALL Medications you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

NAME of medication	DOSAGE	HOW YOU TAKE IT	INDICATION/WHAT YOU TAKE IT FOR

PERSONAL MEDICAL HISTORY: Please LIST and/or CIRCLE all that apply

1)	7)	13)
2)	8)	14)
3)	9)	15)
4)	10)	16)
5)	11)	17)
6)	12)	18)

ADHD	COPD/Emphysema	Kidney Disease	Rheumatoid Arthritis
Alcoholism	Dementia	High Cholesterol	Seizures
Allergies, seasonal	Depression	HIV	Sleep Apnea
Anemia	Diabetes 1 or 2	Hepatitis	Stroke
Anxiety	Diverticulitis	Irritable Bowel Syndrome	Thyroid Disorder
Arrhythmia (irregular Heart beat)	DVT (blood clot)	Lupus	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Liver Disease	
Asthma	Glaucoma	Macular Degeneration	
Bipolar	Heart Disease	Neuropathy	
Bladder Problems/Incontinence	Heart Attack (MI)	Osteopenia/osteoporosis	
Bleeding Problems	Hiatal Hernia	Parkinson's Disease	
Cancer:_____	High Blood pressure	Peripheral Vascular Disease	
Crohns Disease	Kidney Stones	Pulmonary Embolism(PE)	

SURGICAL HISTORY: Please list all prior surgeries and approximate dates performed.

Name of surgery	Date

Health Maintenance / OTHER	Date	Result	Where you had this completed
Colonoscopy		Normal Abnormal	
Mammogram		Normal Abnormal	
Dexa (Bone Density)		Normal Abnormal	
Pap		Normal Abnormal	
Prostate exam		Normal Abnormal	
Last menstrual period	Date: Cycles regular:		
Pregnancies	How many times have you been pregnant: How many deliveries: Miscarriages/Abortions:		

Are there any vision problems that affect your communication? Yes/No

Are there any hearing problems that affect your communication? Yes/No

Are there any limitations to understanding or following instructions

(written or verbal)? Yes/No

SOCIAL HISTORY:

Smoking /Tobacco Use:

Never Current Past Type:_____ Amount/day:_____ # of years_____

Alcohol:

Current Past Never Drinks/week:_____

Substance Abuse:

Current Past Never Type:_____

Occupation: _____

Home/Environment:

Where do you currently reside (home/apartment/residential facility): _____

Who lives with you (significant other, children): _____

Any pets: _____

Diet:

Type of diet: Regular ___, Restricted ___, Diabetic ___, Renal ___, Vegetarian ___,
Other _____

Exercise:

Duration: _____ Times per week: _____ Type of exercise: _____

Sexual history:

Sexually active: ____ Number of current partners: ____
Number of lifetime partners: ____
History of sexually transmitted illnesses: _____

FAMILY HISTORY:

Father: Living/Deceased

Alcoholism Bipolar Depression High Cholesterol Osteopenia/osteoporosis

Anemia Cancer:_____ Diabetes 1 or 2 High Blood pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other:_____

Mother: Living/Deceased

Alcoholism Bipolar Depression High Cholesterol Osteopenia/osteoporosis

Anemia Cancer:_____ Diabetes 1 or 2 High Blood pressure Stroke

Asthma COPD/Emphysema DVT (blood clot) Kidney Disease Thyroid Disorder

Arthritis Dementia Heart Disease Migraines

Other (maternal/paternal aunt or uncle, grandmother or grandfather:_____

_____

Siblings: _____

SPECIALISTS / OTHER PROVIDERS:

List other medical providers you see on a regular basis (i.e. Cardiologist, Pulmonologist, Mental Health Provider, Kidney Doctor, Endocrinologist, OB/GYN, etc) or have seen in the last year:

Name of specialist +/- affiliation with hospital	Indication/what you see them for	Approx date last seen

IMMUNIZATIONS:

To your knowledge, are you up-to-date with your immunizations: Yes / No / Unsure

Please indicate if you have had any of the following vaccines and approximate date:

Influenza vaccine (flu shot): _____

Pneumococcal vaccine (pneumonia shot): _____

Tdap (Tetanus/pertussis shot): _____

Hepatitis A vaccine: _____

Zoster vaccine (shingles shot): _____

Any other immunizations you have had: _____

Childhood vaccines (MMR, Varicella, Hepatitis B, MCV B, MCV ACYW, IPV, Hib, PCV-13, Rotavirus) up-to-date: Yes / No / Unsure

Patient Signature:_____ Date:_____