HAMPDEN PHYSICIAN ASSOCIATES
3456 TRINDLE ROAD, CAMP HILL, PA- 17011
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	**First**:	**Middle:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	**Date of Birth:** / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
City:	State:	Zip Code:		Cell Phone No: ( )	
Occupation:	e-mail (for patient portal):			Work phone no: ( )	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card & driver's license to the receptionist for scanning)

Person responsible for bill:	Date of Birth: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance?	❑ Yes ❑ No		
Please indicate primary insurance	❑ Primary		
❑ Welfare *(Please provide coupon)*		❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone no : ( )	Cell phone no : ( )

- The above information is true to the best of my knowledge. I certify that I, and/or my dependent(s) have insurance coverage with above named insurance company(ies) and assign directly to physician(s) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The physician(s) may use my health care information and may disclose such information to the above-named insurance company (ies) or their agents for the purpose of obtaining payment services and determining insurance benefits or the benefits payable for related services. I understand that I am financially responsible for any balance. I also authorize Hampden Physician Associates or insurance company to release any information required to process my claims. *I grant permission to my physician to view my prescription history from external sources*: - **YES /** NO
- I acknowledge that I have read and agree to HIPPA policy provided to me by *Hampden Physician Associates*.

♦»»» *Patient/Guardian signature:* ____ *Date:* ___________________________

Protected health Information (PHI) & Acknowledgement of Receipt of Notice of Privacy Practices

- I authorize *Hampden Physician Associates* to contact me / leave Protected Health information (PHI) messages by following means: (Please check all that apply)

  Home phone/Answering machine: □Yes □No Phone Number: ___________________

  Cell Phone (Voice/ Text message) □Yes □No Phone Number: ___________________

  Email (patient portal) □Yes □No email: ____________________________

- I further authorize Hampden Physician Associates to discuss with or disclose my personal health information (PHI) to the following individual/s as requested by me. I can further withdraw this request any time by sending a written request to *Hampden Physician Associates*.

  1). ____________________________________ 2). ______________________________________

  Phone: ________________________________ Phone: ___________________________________

Patient signature: ____________________________ Date: ________________________________

I acknowledge that I have read and understand ***HAMPDEN PHYSICIAN ASSOCIATE's*** *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Hampden Physician Associates may update its *Notice of Privacy Practices* at any time and that I may receive a copy of current Hampden Physician Associate's *Notice of Privacy Practices* by submitting a request in writing.

____
Print Patient Name

____________________________________ ________________________
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

____________________________________ ________________________
Printed Patient Personal Representative Name Relationship to Patient

____________________________________ ________________________
Patient Personal Representative Signature Date

HAMPDEN PHYSICIAN ASSOCIATES

3456 Trindle Road
Camp Hill, PA 17011
Phone: (717) 635-2073 Fax: (717) 635-2074

Namrata Haldipur, M.
Harinidevi Krishnan, M.D.

FINANCIAL POLICY

Thank you for choosing Hampden Physician Associates for your care. The following is a statement regarding our financial policy. Please read and sign prior to any treatment.

INSURANCE

We accept assignments for most major insurance companies. We will submit the medical services claim to your insurance carrier if you have given us all the required information. We must have the correct policy, group, ID, or claim numbers along with a correct billing address, and correct date of birth for both the card holder and subscriber. Please be aware that some and perhaps all of the services provided may be "non-covered." Some companies arbitrarily select certain services they will not cover.

- If you receive a denial from your insurance, and you believe they should have paid, it is **YOUR** responsibility to contact them.
- You will receive a monthly statement on any balance not covered by your insurance. Any balance that is 45 days past due will be turned over to the collection agency.
- **Copay is due at the time of service. If you do not have your co-pay, we may have to reschedule your visit. The co-pay is part of your contract with your insurance carrier and therefore your responsibility. If we need to bill you for the co-pay, there may be a $10 charge for the billing.**
- You are responsible for knowing whether or not your policy has a high deductible, or coinsurance responsibilities that you must meet.
- If you have a financial problem and need to discuss a payment plan, please speak to our billing manager. We accept Visa, MasterCard, Discover, American Express, Debit, check and cash payments. Returned checks will be subject to a $30 Bank fee.

IMP: *If you had a previous collection balance or are presently in collection, the physician may use his or her discretion to see you again. It may be required that you pay your previous balance in full prior to being seen. You will be responsible for payment of the office visits, co-pay, deductible, etc on the day of the visit.*

MINOR PATIENTS

The parent/guardian/adult accompanying a minor child is responsible for payment. Any child 18 or over is legally an adult and responsible for his/her bill. (Regardless of attending college, living at home, or being covered by parents' insurance). Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

If you have any questions about the above information or any uncertainty regarding your coverage, PLEASE don't hesitate to ask us. We are here to help.

I HAVE READ THIS FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO IT.

____ **Date:** _____________________________

Signature of Patient or Responsible Party

ORIGINAL

HEALTH HISTORY

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Date:_______________

Patient Name_________________________ Birthdate _____________ Patient #_______________

Chief Complaint ____

History of present illness:

Location:_________________________
(Where is the pain/problem?)

Quality _________________________
(Example: normal versus abnormal color, activity, etc.)

Severity _________________________
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _________________________
(How long have you had this pain/problem?, or, When did it start?)

Timing _________________________
(Does the pain/problem occur at a specific time?)

Context _________________________
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _________________________
____
(What other associated problems have you been having?)

Modifying factors _________________________
____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_______________		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes	_______________		
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_______________		
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes				Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_______________	_______	_______________
_______________	_______	_______________
_______________	_______	_______________

Medications: (Include nonprescription & herbal supplements) _______________________
____
____

Patient social history:

Marital status	Single:_______	Married:_______	Separated:_______	Divorced:_______	Widowed:_______
Use of alcohol:	Never:_______	Rarely:_______	Moderate:_______	Daily:_______	
Use of tobacco:	Never:_______	Previously, but	quit:_______	Current packs/day: _______	
Use of drugs:	Never:_______	Type/Frequency: _______________			
Excessive exposure at home or work to:	Fumes:_______	Dust:_______	Solvents:_______	Air-borne Particles:_______	Noise:_______

HEALTH HISTORY QUESTIONNAIRE

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Brother			
Sister			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in Force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female - # of pregnancies	______	
Female - # of miscarriages	______	
Female – date of last pap smear	______	

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or Hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications:

☐ **Respiratory**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

Known food allergies:________________

Environmental allergies:________________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian ((The above is true and correct to the best of my belief) Date

Doctor's Review

Signature of Doctor Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:______________________________ **Date of Birth:**____________________________

Phone: H) ______________________________ **Phone: W)** ______________________________

Address: ______________________________ **City/State/Zip:** ______________________________

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make / receive record disclosure:

Facility Name: Hampden Physician Assoc

Facility Address: 3456 Trindle Road

City, ST, Zip: Camp Hill, PA-17011

Facility Phone: 717-635-2073

Facility Fax: 717-635-2074

Dates and Type of information to disclose:

- ☐ 2 years prior from the last date seen (by default)
- ☐ Dates Other: ______________________________
- ☐ Specific Information Requested:

____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other______________________________

RESTRICTIONS: Only medical records *originating through this healthcare facility will be copied* unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To / From: ____

Address: ____

City, State, Zip: ______________________________________

Fax: ______________________ **Phone:** ________________

- ☐ **Pick up or Mail CD.**
- ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X______________________________________ ____________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

______________________________________ ____________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative