JOSEPH OBENG (M.D.P.A)

New Patient Registration Form

Patient Name:_____ DOB:_____
Last First M.I.

SSN: _____ Sex: Male_____ Female:_____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Alt. Phone: _____

Employer:_____ Address:_____

City:_____ State:_____ Zip:_____

Pharmacy of choice: _____

Pharmacy phone #: _____

Pharmacy Address: _____

Primary Insurance

_____ Check here if you have no insurance (Cash Account/Self Pay)

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ D.O.B.: _____

SSN#: _____ Relationship To Subscriber: _____

Address (If different from PT): _____

Secondary Insurance

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ D.O.B.: _____

SSN#: _____ Relationship To Subscriber: _____

Address (If different from PT): _____

Patient Signature: _____ Date: _____

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Health Maintenance Screening Tests

Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details. Thank you!

Name: _____ DOB: _____
Marital Status: _____ Number of Children: _____ Occupation: _____

Personal Medical History

Please indicate whether you have had any of the following medical problems:

__ Congenital heart disease __ Congestive heart failure __ Hypothyroidism __ Heart Attack __ Anemia __ Depression __ Hypertension ___ Asthma. ___ Anxiety __ Diabetes __ Atrial fibrillation __ High Cholesterol __ COPD __ Renal Disease ___ Migraines __ Stroke __ GERD __ Seizure Disorder

Other Medical Conditions: _____

Medication

Name	Dose	How Often

Allergies or Reactions to Medications. _____
Surgical History (Please List all Prior Operations and Dates)

Operation	Date

Habits:

Smoker: ___ Packs Daily: ___ How Long? ___ Interested in Quitting? ____ Exercise: ____
Type: ___ How Often: ____
Daily Caffeine Intake (Cups): _____ Alcohol: ____ Tpye: ____

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Amount:_____ How Often:_____ Recreational Drugs: _____ Type:_____ How Often:_____

Preventative Health Care (Please indicate the date and results)

Test	Date	Results (If Indicated)
Colonoscopy		
Mammogram Bone		
Density PSA		
Lab		
Work Tetanus		
Vaccine		

Family History:

Mother's Age _____ if deceased, age at death and cause _____ Father's Age_____ if deceased, age at death and cause_____

Total Number of Brother's and Sister's_____ Living _____

Diagnosis	Family Member	Diagnosis Osteoporosis	Family Member
Hypertension Diabetes		Bleeding Disorder	
Stroke		Glaucoma Depression/	
Cancer		Anxiety Alcoholism	
Heart Disease Thyroid		Migraines	
Disease			

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HIPAA Notification And Communication

Patient Name: _____ Date of birth: _____ Date: _____

Receipt of notice of privacy practices

I have received a copy of the notice of privacy practices for Dr. Joseph Obeng MD PA

_____	_____	_____
Signature of patient or representation	Relationship	Date

Communication of Confidential Information

I request that the following person(s) be provided information regarding my: Healthcare, Treatment Plans and / Or Financial Transactions

_____	_____	_____
Signature of patient or representation	Relationship	Date
_____	_____	_____
Signature of patient or representation	Relationship	Date

JOSEPH OBENG (M.D.P.A)

Consent to Treat

Patient Name: _____ D.O.B: _____

By signing this form, I voluntarily consent to receive medical treatment for the above named facility. Medical Treatment may include, but are not limited to, interview, examination, test and procedures deemed appropriate by the treating provider.

_____ _____

Patient Signature **Date**

Dr. Joseph Obeng MD PA Polices

Welcome and Thank You for choosing Dr. Joseph Obeng MD PA for health needs. We are committed to providing you with the highest quality medical care in an efficient, timely and cost effective manner.

1. **Patient is responsible for Deductible, Coinsurance and Co-Pays and Non-Covered Services as well as any cost insurance may not cover. You will be sent an itemize statement regarding the monies that you owe.**
2. **Please arrive to appointment a few minutes early to give us any changes that may have changed on your account and any paperwork that you may have to give the Front Desk as Well.**
3. **We accept CASH, VISA, MASTERCARD, CHECKS as mean of payment, however WE DO NOT TAKE AMERICAN EXPRESS**
4. **If you arrived more that 15 Minutes late to your appointment, you may be asked to rescheduled or wait for the other patients who made it on time to be seen first before you are seen.**
5. **We require a 24-hour notice if you must cancel or reschedule your appointment. We reserve the right to charge a $25.00 fee for NO-Show/ Late Cancellations**

_____

Patient Name and Signature

JOSEPH OBENG (M.D.P.A)

Notice of Privacy Practice

This notice describes how medical information about you may about you may be used and disclosed an how you can get access to this information. Please Review it carefully. Privacy and protection of personal information is an important principle to Dr. Joseph Obeng MD PA. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the services we provide. This document describes our privacy policies. We are required by law to maintain the privacy of your health information (protected health information of PHI) and to provide you with this notice of our legal duties and privacy practices with respect to your OHi and have you sign a written acknowledgment that you received the notice. When we use or disclose your PHI, We are required to abide by the terms of this notice.

Permissible Uses and Disclosures with your Written Authorization

In certain situations we must obtain your written authorization in order to use and/ or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

- Treatment. We use and disclose your PHI to provide treatment and other serves to you.
- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you

Healthcare Operations: We may use and disclose your health information in connection without healthcare operations. Healthcare Operations include Quality Assessment and Improvement Activities, Reviewing the Competence or Qualifications of healthcare professionals, Evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activates

Your Authorization: In addition to our use of your health information for treatment payment or healthcare operations you may give us written authorization to use your health information or disclose It to anyone for any purpose. You have the right to revoke automation at any time. You revocation will not affect any use if disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason expect those described in this notice.

Family and Friends: We must disclose your health information to you, as described in the patient rights section if this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment of healthcare, but only if you agree that we may do so.

Person's Involved in Care: We may use or disclose health information to notify, or assist in the notification of(including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of an emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only information that will be use in the circumstance. We will also use our professional judgment with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other forms of medical health.