

NEW PATIENT REGISTRATION

COMPASSION SERVICES, LLC

140 ADAMS LANE SUITE 300

PIKEVILLE, KY 41501

PH: 606-230-2255 FAX: 606-437-3001

PATIENT INFORMATION:

Patient Last Name, First Name:		Birth Date:	Male <input type="checkbox"/>	Home Phone:
			Female <input type="checkbox"/>	
Street Address:			Apt. No.:	Cell Phone:
City:	State:	Zip Code:	E-mail:	

EMERGENCY CONTACT:

Name:	Cell Phone:	Home Phone:	Relationship:
Name:	Cell Phone:	Home Phone:	Relationship:

PRIMARY INSURANCE INFORMATION:

Insurance Name:	Insurance Phone:
Policy Holder Name:	Relationship with Patient:
ID/ Policy #:	Group #:
Insurance Address:	City and State:

PREFERRED LANGUAGE:

- English Spanish Portuguese French Creole
 Chinese Other: _____

PATIENT'S RACE:

- Hispanic Not Hispanic Prefer not to answer Other: _____
 White Black/African American Asian American Indian Native Hawaiian/Pacific Islander

PATIENT'S ETHNICITY:

- Dominican Non Hispanic Mexican Other: _____
 Cuban Hispanic/ Latino Puerto Rican South American Central American

PHARMACY:

* This is where all of your prescriptions will be electronically sent in the near future.

* We need physical address or nearest intersection for the pharmacy of your preference.

- CVS Walgreens Publix Target Wal-Mart
 Other: _____

Address: _____

Phone: _____

Parent/ Legal Guardian & Person Financially Responsible:

SIGNATURE: _____

DATE: _____

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Patient's Name: _____

D.O.B.: _____

PARENT/ LEGAL GUARDIAN INFORMATION:

Parent/ Legal Guardian's Name:		Birth Date:	Social Security No.:
Cell Phone:	Work Phone:	Place of Employment/ Occupation:	
Parent/ Legal Guardian's Name:		Birth Date:	Social Security No.:
Cell Phone:	Work Phone:	Place of Employment/ Occupation:	

Name of all person's living in the patient home at the present time:

NAME:	AGE:	RELATIONSHIP:	OCCUPATION:

FAMILY MEDICAL HISTORY (check & circle all that apply):

- Heart Disease : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
- Asthma : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
- Cancer : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
Type of Cancer: _____
- Diabetes : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
- Ovarian Cyst : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
- Thyroid Disease : Mom Dad Maternal Gma Maternal Gpa Paternal Gma Paternal Gpa Sibling
Type of Thyroid Disease : _____
- Other(s): (list): _____

PATIENT'S BIRTH HISTORY:

Where was the patient born? (Hospital and City) _____

Birth Wt.: _____ Birth Ht.: _____ Gestational Age (Weeks): _____

Cesarean Section NSVD (Vaginal delivery)

Problems/ Complications (List): _____

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Patient's Name: _____ **D.O.B.:** _____

ALLERGIES:

- MEDICATION: (List type of reaction)

- FOOD: (List type of reaction)

PATIENT MEDICAL HISTORY (check all that apply):

Past Surgical History:

- Tonsils Removed
- Adenoids Removed
- Inguinal Hernia Repair
- Ear Tube Placement
- Heart
- Umbilical Hernia Repair

Other (s): _____

Hospitalizations: None Yes

Reason (If any): _____

Medications:

- Daily Medications or Vitamins (include dosage) :

Has Patient ever had any of the following: (check as many as apply)

- ADD / ADHD
- Allergic Rhinitis (allergies)
- Anemia, Hemophilia
- Asthma
- Atopic Dermatitis (Eczema)
- Autism
- Bronchiolitis / Wheezing
- Cancer
- Cerebral Palsy
- Developmental Delay
- Diabetes
- Frequent Ear Infections
- Hay Fever / Allergy
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- Obesity
- Pneumonia
- Seizures (Epilepsy)
- Sinusitis
- Varicella (chickenpox)
- Other (s): List:

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Patient Consent Record:

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf. You may appoint anyone that is over the age of 18 years to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name: _____
Last Name First Name Middle Name Date of Birth

For occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

Name Relationship to Patient Phone #

Name Relationship to Patient Phone #

_____ (Initial here) if you wish to give consent for the minor to receive medical care without an accompanying adult, which will be in effect for: _____ days only, or _____ (initial here) indefinitely, until revoked by written communication. Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent or legal guardian must be in attendance. By signing form parent or legal guardian agrees and grants authorization to the individual(s) above to sign consent for immunization administration as well as any minor procedures. COMPASSION SERVICES, LLC assumes that both parties are in complete agreement and therefore will not be held responsible for any miscommunication between parties.

It is policy of this office that the adult presenting the child for treatment, or the child if they are seen without an adult present, is responsible for payment of the patient portion at the time of service. I have read, understand, and give my consent as stipulated above.

Parent or Legal Guardian Relationship to Patient Date

Printed Name Phone Number

Any cancellations that occur less than 24 hours prior to the appointment time will accrue a **No Show** charge of \$25.00 and must be paid upon arrival before the patient can be seen.

If the patient calls 24 hours prior to their appointment time they will not be charged for the No Show.