FRANKLIN MEDICAL CONSULTANTS P.C.

Arthur Rose, M.D.
Sumner Camisa, M.D.
Kwan Yee, M.D.
Joyce Yeghissian, D.O.
Rita Sharma, M.D.
Manuel Sklar, M.D.
George Artzberger, D.O.
Renda Dawud, M.D.

29829 TELEGRAPH ROAD, SUITE 100
SOUTHFIELD, MI 48034
Phone (248) 355-3033 Fax (248) 355-4936
http://franklinmedicalconsultants.com

PATIENT REGISTRATION FORM
PLEASE FILL FORM OUT COMPLETELY

Name_____ Social Security #_____-____-_____

Birthdate (MM/DD/YYYY) ____/____/_____ Age_____ Sex_____

Email Address_____

Marital Status_____ Referred by_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Who do we call in an emergency?_____

Emergency Contact Phone (_____) _____-_____

Employer_____ Phone (_____) _____-_____

Insurance_____ Cardholder_____

Card Holder's Social Security #_____-____-_____

Card Holder's Birthdate (MM/DD/YYYY) ____/____/_____

If you fail to show up for a scheduled appointment, a fee will be charged unless we are notified at least 24 hours in advance.

Authorization: I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by treatments or examinations that I (or the patient) will receive as a result of services. I authorize the release of my medical records, including: alcohol and drug abuse records protected under the regulation in Code 42 of Federal Regulations, Part 2; psychological services records, if any; social services records, if any including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatments for Acquired Immune Deficiency Syndrome (AIDS), if any; and records of a communicable disease, if any; to my insurance company(s) for the purpose of payment of a bill and to my health care provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance.

I understand that if any employee, physician, or agent of Franklin Medical Consultants P.C. sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I HEREBY CERTIFY THAT THE CONTENTS OF THIS FORM ARE UNDERSTOOD BY ME. PARAGRAPHS OR LINES THAT I CHOOSE NOT TO PERTAIN TO ME, IF ANY, WERE STRICKEN BEFORE I SIGNED.

Signature_____ Date (MM/DD/YYYY)____/____/_____

Witnessing Signature Only_____

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Dear Patient,

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescriptions to mail order pharmacies.

To implement this program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy, however, you may also provide the information for additional pharmacies to be used as an alternate. In addition, if you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

PATIENT NAME_____ DOB (MM/DD/YYYY)____/____/_____

Please list your drug allergies:

No known drug allergies (please circle if this applies to you)

MAIN PHARMACY:

Name (i.e. CVS, Rite-Aid, etc)_____

Street Name and City_____

Phone (_____) _____-_____ Fax (_____) _____-_____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:

Name (i.e. CVS, Rite-Aid, etc)_____

Street Name and City_____

MAIL ORDER: (please circle)

MEDCO	EXPRESS SCRIPTS	RIGHTSOURCE
CVS / CAREMARK	ADVANTAGE	SILVERSCRIPT

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

Patient Signature_____

Date (MM/DD/YYYY)____/____/_____

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On _____, 20_____, _____ presented

_____(the "patient")

The patient refused to provide a signature when requested.

RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom we may discuss your condition and/or treatment with.

____Spouse: Name_____

____Immediate Family Member: Name(s)_____

____Friend(s): Name(s)_____

Please do not discuss my treatment with: Name(s)_____

Signature_____ Date (MM/DD/YYYY)____/____/_____

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Patient Name_____ Birthdate (MM/DD/YYYY)____/____/_____

Doctor_____

In order to comply with the US government requirements regarding Electronic Health Records (EHR) we need the following information:

Ethnicity (please check one):

Patient Declined____
Check if NOT Hispanic or Latino____
Check if Hispanic or Latino____ (specify below):

- ____Spaniard
- ____Mexican
- ____Central American
- ____South American
- ____Latin American
- ____Puerto Rican
- ____Cuban
- ____Dominican

Race (select up to three):

- ____Patient Declined
- ____Unknown to Patient
- ____American Indian or Alaska Native
- ____Asian
- ____Black or African American
- ____Native American or Pacific Islander
- ____White
- ____Other

Primary Language_____

Allergies_____

Contact Preference (Please Choose 1 Only)

Home Phone (_____) _____-_____

Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

Email_____

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Date (MM/DD/YYYY)____/____/_____

Patient Name_____

Patient Date of Birth (MM/DD/YYYY)____/____/_____ Gender: Male____ Female____

Last PSA (MM/DD/YYYY) ____/____/_____

Last Pap Smear (MM/DD/YYYY) ____/____/_____

Last Mammogram (MM/DD/YYYY) ____/____/_____

Last Complete Physical (MM/DD/YYYY) ____/____/_____

Last Colonoscopy (MM/DD/YYYY) ____/____/_____

Last Eye Exam (MM/DD/YYYY) ____/____/_____

Smoking:

Smoker	YES	NO	(Please Circle One)
Former Smoker	YES	NO	(Please Circle One)

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____