Francois J du Toit, MD

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Preffered Pharmacy and Location:		Cell Phone:	How Long at current Employer?
E-mail address:		Race:	Nationality:
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Birth date	Social security #	Business phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes ✓ ☑ No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #
Workman's Comp Y / N				
Motor Vehicle Accident Y / N	Date of Accident:	Place of Accident:		

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Dr Francois J du Toit, MD for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Dr Francois J du Toit, MD for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Men Only:

1. PSA: YES NO

   Date of last PSA _____

2. Colonoscopy: YES NO

   Date of last colonoscopy _____

Medication Allergies:

1. _____

2. _____

3. _____

Women Only:

1. How many children do you have? _____

2. Date of Last Menstrual Cycle: _____

3. Menopause: YES NO Date: _____

4. Last PAP: _____

5. Last Mammogram: _____

6. Last Bone Density:
   _____

7. Colonoscopy: YES NO Date:_____

Social History:

1.Use of Alcohol: ___ Never ___ Rarely
___ Moderate ___ Daily

2. Use of Tobacco: ___ Previously, but quit
___ Never ___ Currently
___ Packs per day

3. Use of Drugs: ___ Previously, but quit
___ Never ___ Currently
Type of drugs used: _____
_____

Hospitalizations:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Surgeries:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Medications:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____