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 #
Insurance Subscriber:	Subscriber Birthdate:		Subscriber Social Security #:	

Insurance Authorization for Assignment of Benefits/Information Release:

I authorize the release of medical information necessary to process this claim or provide medical information to my insurance carriers, or to any physician or medical facility. I authorize payment of medical benefits to Francois J. du Toit, MD for all professional goods and services rendered. I understand that I am financially responsible for any charges whether or not covered by insurance. I also authorize e-Med Hx request to retrieve all of my prescriptions.

_____ _____
Patient Signature Date

HIPAA:

I hereby request to be contacted at the number(s) below to receive personal private health information. I also designate another person listed below to receive appointment information as well as limited health information regarding my care as I designate. I acknowledge that I received/reviewed a copy of Provider's Notice of Privacy Practices. I am aware of my privacy rights. I understand that this authorization will remain effect until revoked in writing by me.

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

Additional designated persons other than the patient, relationship, and contact number:

_____ _____

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. _____